Personalize Home Care Service, LLC

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Physician Certification of Need and Orders for Home Health Services

Patient Name: (Last, First)			Physician Ordering Home Health Services: Dr: Phone: Fax: Address:
Date of Birth:	SSN#:	Sex: Male Female	
Telephone: Alternate Phone:			
Address for Care:			Referral Date: Primary Problem for Home Health Care: Additional Diagnoses:
Primary Insurance: Insurance Number: Secondary Insurance: Insurance Number:			

EVENT PROMPTING REFERRAL	CARE PLAN OVERSIGHT
☐ Hospital/Facility stay from _____ to _____ for primary problem noted above. Hospital/SNF Physician may complete the attestation of face to face encounter within 90 days prior to Start of Care date for Home Health Services. ☐ Face to Face encounter on _____ Re: primary problem for Home Health. Encounter must be within 90 days prior to Start of Care date for Home Health Services. ☐ No Face to Face encounter for the primary problem note above has occurred within the past 90 days. **MUST COMPLETE BELOW.**	**Will the ordering physician sign and oversee the plan of care:** ☐ **Yes** ☐ **No** If NO, which Physician sign and oversee the Plan of Care? Dr: _____ **----------SERVICES ORDERED----------** **Choose on box with your order for SOC date:** ☐ SOC on a specific date _____ OR ☐ Within 48 hours of SOC referral (standard) The following services are medically necessary: ☐Skilled Nurse ☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy ☐Home Health Aide ☐Medical Social Worker
---CMS REQUIREMENTS *IF* NO FACE TO FACE----	**---ATTESTATION of FACE to FACE ENCOUNTER---**
Encounter Due Date: _____ Must be within 30 days after SOC – see order date in "services ordered' area **Physician who will perform (or have NPP* perform) the Face to Face encounter & oversee the Plan of Care:** Dr: _____	**My clinical findings support the need for home health services as follows:**_____ _____ _____ _____ _____ _____ _____

I CERTIFY MY CLINICAL FINDINGS SUPPORT THAT THIS PATIENT IS HOMEBOUND PER CMS GUIDELINES DUE TO:

_____

_____

(Include a physical conditions, mental Impairments, physician-ordered restrictions)

I CERTIFY that this patient is under my care and that I had a face to face encounter that meets the Physician Face to Face requirements with this patient as noted above.

Signature of Physician: **X**_____	Signature Date: **Date:** _____

Content of form based on CMS Calendar Year 2011 Final Rule Face to Face Encounter requirements.