HAVEN HOME HEALTH, LLC

Experience the difference in patient care!

TOP 500 HomeCare Elite 2010 AGENCY

PHYSICIAN CERTIFICATION OF FACE TO FACE ENCOUNTER

PATIENT

Last Name: _____ First Name: _____ MI: ____

Date of Birth _____/_____/_____ Medicare Number: _____

Date of Last Patient Face to Face Encounter: _____

Clinical Findings supporting the need for skilled nursing and/or therapy home health:

_____

_____

_____

Clinical Findings Supporting **Homebound Status**: _____

_____

_____

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care or will be transferred to the care of his/her physician and I have authorized home health services.

Physician Name: _____ Office Contact: _____

Physician Signature: _____ Date: _____

Telephone: _____ Fax: _____