Heavenly Health Care
1506 E. Griffin Parkway, Suite B
Mission, TX 78572
Phone: (956) 271-4755 | Fax: (956) 598-5098

PHYSICIAN FACE TO FACE ENCOUNTER

Patient:

Physician:

MR#:

Order #:

DOB: **SOC:**

Episode:

☐ POC Certifying Physician ☐ Non-POC Certifying Physician

I certify that the above named patient is under my care and that I, or the nurse practitioner or physician's assistant working with me, had the required face-to-face encounter meeting the encounter requirements on the date below.

Face To Face Encounter Date ______________________

The medical reason, diagnosis, or condition related to the primary reason for home healthcare for the encounter was

Clinical findings that support the medical need for home health services and support home patient's homebound status are as follows

I hereby certify that based on my clinical findings, the patient is homebound and the following home health services are medically necessary.

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy
☐ SpeechTherapy ☐ Home Health Aide ☐ MSW
☐ Other ______________

Physician Signature: **Date:**