UPMC Visiting Nurses
PLEASE COMPLETE ALL SECTIONS AND RETURN TO CENTRAL INTAKE:
Fax #: 724-778-4747

☐ North Branch ☐ South Branch

☐ Horizon Branch ☐ Ohio Subunit

Home Health Physician Documentation of Face-to-Face Encounter

Patient Name: _____ DOB: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on:

Date patient was seen: _____
Month Day Year

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care **(list medical condition):**

_____
_____

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

_____Nursing
_____Physical therapy
_____Speech language pathology

My clinical findings support the need for the above services because (i.e.: skilled assessment, teaching, wound care, medication management, rehabilitation):

_____
_____
_____

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

_____
_____
_____

Certification for Home Health services:
Based on the above findings, I certify that this patient is confined to the 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, and I have initiated the establishment of the plan of care. This patient will be followed by a physician who will periodically review the plan of care.

Physician Signature: _____ Date: _____

Physician Printed Name: _____

FOR OFFICE USE ONLY

Admission #: _____ **Insurance:** _____

Document #: _____

ds Rev 01-2014