VERGE HOME CARE

Physician Face to Face Encounter
4622 S. Closner Blvd., Edinburg TX 78539
TEL (956) 287– 7575 FAX (956) 287 – 7979

PATIENT INFORMATION

Patient Name:				**Date of Birth:**	
Address:					
City:		**Zip:**		☐ **Male**	☐ **Female**
Phone Number:				**Cell Number:**	
Medicare #:				**Medicaid #**	

PHYSICIAN INFORMATION

Physician Name:					
Address:					
City:		**Zip:**		**Phone Number:**	

PHYSICIAN FACE TO FACE ATTESTATION – To be filled out by physician office

I certify that my clinical findings support that this patient is homebound because:

(i.e. needs assistance for all activities, residual weakness, requires max assistance/taxing effort to leave home, confusion/unsafe to go out of home alone, SOB/SOB upon exertion, unable to safely leave home unassisted and/or any other clinical findings that effect homebound status. Note that pt requires considerable or taxing effort to leave their residence for medical reasons and religious services or infrequent or of short duration for other reasons)

The encounter with the patient was in whole, or in part to the medical condition for which the patient needs home health services (list medical condition) : _____

My clinical findings support the need for the requested home health services:_____

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 meet the physician face-to-face encounter requirements.

_____ (Date office visit occurred)

I certify that based on my clinical findings, the following home health services are medically necessary for this patient (Mark all that apply)

☐ Skilled Nurse ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

M.D.	**Date:**
X	

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