Memorial Home Care Services MAIN 509-746-3800 | FAX 509-574-3654
Cottage in the Meadow | 1208 South 48th Avenue | Yakima, WA 98908 | MAIN 509-746-3801 | FAX 509-574-6755

Home Health Referral

Medicare Face-to-Face Encounter Documentation/Certification

This form must be completed and signed by a physician, nurse practitioner, or physician's assistant, per Medicare guidelines.

A face-to-face encounter (medical visit) is required for Medicare patients within the 90 days prior to, or the 30 days following, the start of home health services. It is the agency's policy to discharge patients who have not had a face-to-face encounter per Medicare guidelines.

Patient Name: _____ **DOB:** _____

- Date of Face-to-Face patient encounter: _____
- Clinical findings supporting the medical necessity for Home Health services:

  _____

  _____
- The patient is confined to home (absences from home require considerable and taxing effort and are for medical reasons/religious services/infrequent or sort duration) due to my clinical findings of:

  _____

  _____

THE FOLLOWING SKILLS ARE MEDICALLY NECESSARY FOR HOME HEALTH CARE:

PRIMARY SERVICES	SECONDARY SERVICES (MUST have a primary service)
Nursing ☐ Evaluate and treat, 1-3 visits weekly	**Occupational Therapy** ☐ Evaluate and treat, 1-3 visits weekly
Physical Therapy ☐ Evaluate and treat, 1-3 visits weekly	**Medical Social Worker** ☐ Evaluate and treat, 1-3 visits monthly
Speech Therapy ☐ Evaluate and treat, 1-3 visits weekly	**Home Health Aide** ☐ Evaluate and treat, 1-3 visits weekly

It is acceptable to admit this patient to Home Health outside of Medicare timely admission requirement in the event the agency is unable to schedule the initial visit within 48 hours. ☐ **Yes** ☐ **No**

Comment: _____

I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy, occupational therapy and/or speech therapy. I have initiated the plan of care and referred this patient to _____, a community physician, who will follow and periodically review the plan of care. I further certify this patient had a face-to-face encounter that was performed on the date noted above by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

Physician Signature: _____ **Date:** _____

Physician Printed Name: _____