HAVEN HOME HEALTH, LLC

Experience the difference in patient care!

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:

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Clinical Findings Supporting **Homebound Status**: ____

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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: _________________________________