MedSide healthcare
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Sandy Springs,
GA 30350
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Home Health Referral
Face to Face Encounter

Demographics [may be attached]:

Patient's Name: _____ **Date of Visit:** _____

Date of Birth: _____ Sex: _____ Primary Insurance: _____

SSN: _____ Policy Number: _____

Address: _____ Secondary Insurance: _____

City: _____ State: GA Zip: _____ Policy Number: _____

Phone: _____ Primary Care Physician: _____

The encounter with this patient was in whole or in part for the following **medical condition/diagnosis** which is the primary reason for home health care: _____

This patient is under my care. I have established a plan of care, and it will be reviewed by a physician periodically. I have authorized the home health services. I refer to MedSide Healthcare and certify, that based on my findings, the following services are medical necessary.

My clinical findings support the need for the Home Health services:

__ Intermittent Skilled Nursing Care **for** _____

__ Physical Therapy **for** _____

__ Speech Therapy **for** _____

__ Continues to need Occupational Therapy **for** _____

__ Medical Social Work **for** _____

__ Home Health Aide **for** _____

Additional Instructions: _____

I certify that this patient is "confined to home" (homebound) based on meeting both of the following criteria:

Criteria 1.
Because of illness or injury, patient needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence. Please Specify:

_____

OR

Please specify a condition in which leaving his/her home is medically contraindicated:

_____

Criteria 2.
What causes the patient the inability to leave the home **AND** why does leaving the home require a considerable and taxing effort?

_____

_____

_____

_____

I certify that this form was completed based on a face-to-face encounter that meets the physician face-to-face encounter requirements. The form was completed by a physician based on a face-to-face encounter or information provided by a nurse practitioner, physician's assistant, certified nurse midwife, or clinical nurse specialist working in conjunction with the certifying physician or physician who cared for this patient in an acute or post-acute facility.

Physician's Name: _____ **NPI:** _____

Physician's Signature: _____ **Date:** _____

Office Contact: _____ **Phone Number:** _____ **Fax Number:** _____