10 Emory Street
Attleboro, Massachusetts 02703
TEL 508.222.0118 or 800.220.0110
Medical Records Fax: 508.226.3573

Physician Face to Face Patient Encounter Form

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 within 90 days prior to or within 30 days of the start of home health services with this patient.

The face to face encounter occurred on:____
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):

____

My clinical findings support the need for skilled services (nursing, physical or speech therapy) because:

____

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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:

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Physician Signature:____

Date of Signature:____

Physician Printed Name:____