

Home Health Face-To-Face Encounter Form

ADDENDUM TO PLAN OF TREATMENT: Face-Face Encounter

1. Patients HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.
6. Patients name:		7. Provider Name: Kansas City Palliative Home Health Care		

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 meets the physician face-to-face encounter requirements with this patient on:

_____/_____/_____
Month Day Year

The encounter with the patient was in whole, or part, for the following medical condition, which is the primary reason for home health care (list medical condition):

I certify that, based on my findings, the following services are medically necessary home health services (check all that apply):

____ Nursing ____ Occupational Therapy
____ Physical Therapy ____ Speech Language Pathology

My clinical findings support the need for the above services because:

Further, I certify that my clinical findings support that this patient is homebound (ie, absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration for other reasons) because:

Physician Signature: _____

Signature Date: _____

Printed Name/Address: _____



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