ACTIVE LIVING HOME HEALTH CARE, LLC

IMPROVING HEALTH. CHANGING LIVES.

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Physician Certification of Need and Orders for Home Health Services

Patient Name: D.O.B ________/________/________

Last: First:

Patient Address:

City: State: Zip:

Patient Phone Number:

Secondary:

Caregiver:

Relationship:

Phone Number:

Patient Insurance

Medicare:

Medicaid:

BXBS:

Other:

Physician Ordering Services

Dr:

Phone:

Fax:

Address:

NPI#

PECOS Registered? ☐ Yes ☐ No

Care Plan Oversight

Will the Ordering Physician Sign and Oversee the Plan of Care?

☐ Yes ☐ No If No, which physician will sign and oversee the plan of care?:

DR:____

Services Ordered

Choose one box with your order for SOC date:

☐ SOC on a specific date _________/_________/_________

☐ Within 48 hours of SOC referral (standard)

The following services are medically necessary:

☐ Skilled Nursing
☐ Occupational Therapy
☐ Home Health Aide
☐ Mental Health Services
☐ Speech Therapy
☐ Social Worker
☐ Physical Therapy

Diagnosis

VERIFICATION OF PHYSICIAN AND PATIENT FACE-TO-FACE ENCOUNTER (MUST BE COMPLETED)

DATE OF PHYSICIAN ENCOUNTER __________/__________/__________

MEDICAL REASON FOR ENCOUNTER:

CLINICAL FINDINGS:

____

____

REASON PATIENT IS HOMEBOUND:
(examples: leaving home is a taxing effort, patient is unable to leave home unassisted or due to medical restrictions)

____

____

____

I certify that this patient is under my care and that I have had a Face-to-Face encounter that meets Physician Face-to-Face requirements with the patient noted above.

Signature of Physician or NPP who performed Face-to-Face encounter and
informed certifying Physician if needed:

X____ DATE _________/_________/_________