TOP AID
HEALTHCARE, INC

PHYSICIAN FACE-TO-FACE ENCOUNTER FORM

Patient Name:· _____ Date of Birth:_____

Date of Face-to-Face Encounter: I certify that this patient is under my care and that I, or a Nurse Practitioner or Physician Assistant working with me, had a face-to-face encounter with this patient that meets the physician face-to-face encounter requirements (please insert date that visit occurred).

_____ _____ _____

Month Day Year

Medical Condition: The encounter with the patient was in whole, or in part, for the following medical condition which Is the primary reason for home care. (Please list ALL medical conditions).

_____

_____

_____

Medical Necessity: I certify, that based on my findings, the following services are medically necessary home care services (Please check all that apply) .

Nursing_____ Occupational Therapy_____

Physical Therapy_____ Home Health Aide_____

Speech Language Pathology _____ Other_____

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

_____

_____

_____

Homebound Status: Further, I certify that my clinical findings support that this patient is homebound because:

_____

_____

_____

Physician Signature: _____ Date,_____

Physician Printed Name,_____