

# Bluebonnet Home Health and Hospice

## VERIFICATION DOCUMENTATION OF FACE-TO-FACE ENCOUNTER

---

PATIENT NAME AND IDENTIFICATION

### Certification Date

---

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: (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 health care (list medical condition):

### Services Needed

---

I certify that, based on my findings, the following services are medically necessary home health services (*check all that apply*):  Nursing  Physical Therapy  Occupational Therapy  Speech Language Pathology  
To provide the following care/treatments: **(Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):**

### 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 (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:

- Residual Weakness       Unable to leave home Unassisted       Medical Restriction  
 Dependent on adaptive devices       Unable to ambulate without assistive device  
 Other \_\_\_\_\_

### Certification

---

Physician Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Physician Printed Name: \_\_\_\_\_