Home Health Care Face-to-Face Encounter Form

(Fax this completed form along with the discharge plan to BG Healthcare Services, Inc.)

Falls Church Office:
450 W. Broad St., Suite 420
Phone: (703) 533-0311
FAX: (703) 533-0312

Leesburg Office:
116 Edwards Ferry Rd., NE., Suite H
Phone: (703) 771-4861
FAX: (703) 771-4862

Patient Name:	**Date of Birth:**

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:

DATE VISIT OCCURRED: _____ / _____ / _____
MM DD YYYY

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 CONDITIONS:

_____
_____
_____
_____

I certify that, based on my findings, the following services are medically necessary for home health services (**Check all that apply below**)

Must have at least one stand-alone service:	**Additional Services:**
☐ Nursing	☐ Occupational Therapy
☐ Physical Therapy	☐ Home Health Aide
☐ Speech Language Pathology	☐ Social Worker

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

_____
_____
_____

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, religious services, infrequently or of short duration when for other reasons) **because:**

_____
_____
_____
_____

_____
Physician Signature:

_____
Physician Printed Name:

_____ _____
Date of Signature: **Time of Signature:**

Must be completed by the referring physician for all Medicare patients referred to BG Healthcare Services, Inc.