Revised 05/24/12

Phone: 248.731.7457 Fax: 248.731.7562

Continuing Plan of Care/Face-to-Face Certification

Referral Date: _______ SOC: _______

MR#: ___________

Patient's Name: ____________________
Gender: Male ______ Female ____
Address: ________________________________
____

Home Phone: ____________________________
SS#: ________________________________
Date of Birth: ____________________________

Emergency Contact: ______________________
Relationship: ____________________________
Phone: __________________________________

Physician Name: ____________________________
Phone: ____________________________________
Address: __________________________________
____

NPI: _____________________

Medicare #: ____________________________
Other Insurance: _________________________
Policy #: ______________________________
Subscriber Name: ________________________
DOB: __________________________________

V.O. Communicated By:
____

Face to Face Encounter Date: _________

Certification Period: _______ - _______

Clinical Findings/Need for Skilled Services/Diagnoses Related to Home Care:
____
____
____

Co-morbidities affecting POC:
____
____
____

Initial Orders / Others:
____
____
____
____
____

☐ Reconcile Meds @ Patient's Home

☐ Check Immunization Status

☐ Evaluate need for other appropriate participating disciplines

SN: _____________ PT: ________________
OT: _____________ ST: _________________
HHA: _____________ MSW: ______________
RD: ________________ Others: ______________

The face to face encounter with the patient occurred because the patient was being treated for the medical conditions listed in the problem list above, which is/are related to the primary reason the patient requires home health services. I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

MD Signature: ____ **Date:** ________________

(I understand that I will receive a POC/485 for signature after full evaluation/ assessment of the above patient.)

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