NATIONAL HOME CARE
25210 Five Mile Rd
Redford Mi 48239
PH: (313) 387-1571 FX: (866) 364-7300
www.nhcmi.com

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 ☐ Physical Therapy ☐ Speech Therapy

☐ Occupational Therapy ☐Home Health Aide ☐ Social Worker

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 _____/_____/_____

Content of form based on CMS Calendar Year 2011 Final Rule Face to Face encounter requirements. *NPP- Non Physician Practitioner or clinical Nurse specialist in collaboration with Physician or Physician Assistant under the supervision of the Physician who will oversee the Plan of Care