FACE TO FACE ENCOUNTER
COMMUNITY HOME HEALTH CARE

Community HOME HEALTH CARE INC.
"Creating Happier Healthier Communities"

Tel: (717) 261-2546 **CHAMBERSBURG** **Fax: (717) 263-3614**

PATIENT LAST NAME FIRST NAME	PRIMARY PHYSICIAN'S NAME PHONE FAX
PATIENT'S ADDRESS PHONE ZIP	INTAKE DATE: REQUESTED 1ST VISIT DATE:
EMERGENCY CONTACT PERSON PHONE	SOCIAL SECURITY NO.
COMPLETE BIRTH DATE / SEX M F / MARITAL STATUS S M W D Sep	PRIMARY INSURANCE
HOSPITAL/INPATIENT FACILITY / PHONE	OTHER INSURANCE
ADMISSION DATE / DISCHARGE DATE	

I certify that this patient is under my care and I, the referring physician, a nurse practitioner, or physician's assistant working with me, had a face to face encounter (FFE) with this patient.

Date of FFE: _____

__ Skilled Nursing
__ Medical Social Worker
__ Home Health Aide
__ Physical Therapy
__ Occupational Therapy
__ Speech Therapy

My clinical findings that support the need for the above mentioned home health services are as follows:

_____
_____
_____

I certify my clinical findings support that this patient is homebound per CMS guidelines due to:

_____
_____
_____

Special Instructions:

Physician's Signature _____ Date: _____