Pinnacle HOME HEALTHCARE, INC. ©

"Let Us Bring Our C.A.R.E. To Your Home"

Physician's Orders / Face to Face Visit Verification

Patient Name: _____ DOB: _____

Address: _____ City / zip: _____

_____

Phone #: _____ Medicare / Insurance #: _____

_____

The encounter with the patient was in whole, or in part, for the following medical condition, which is related to the need for the home health care services ordered below. (List medical condition):

_____

_____

Based on my findings, I certify and prescribe the following home health services as medically necesssary:

Home Health Order(s):

- ☐ Skilled Nursing
- ☐ Psychiatric Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Lymphedema Therapy
- ☐ Speech Therapy
- ☐ Medical Social Work
- ☐ Home Health Aide
- ☐ Other _____

Specialty Program

- ☐ Cardiac / CHF Care
- ☐ Diabetic Care
- ☐ Neurological Care
- ☐ Medication Management
- ☐ Strengthening / Balance Program
- ☐ Ostomy Care
- ☐ COPD Care
- ☐ Stroke Care
- ☐ Wound Care

Detailed orders (if necessary): _____

_____

Further, I certify that my clinical findings support that this patient is homebound because:

_____

_____

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: _____/_____/_____.
Month Day Year

Physician's Signature: _____

Physician's Printed Name: _____

Date: _____ Time: _____

OFFICE USE ONLY
Orders Received By: _____
Date: _____ Time: _____

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