



Visiting Nurse Association of Chittenden & Grand Isle Counties

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Physician Documentation of Face to Face Encounter
(Required for Medicare Payment of Home Health Services)

Patient Name _____ DOB _____

1) 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 with this patient on: (Insert date of encounter below)

Month Day Year

2) I certify that the encounter with the patient was in whole, or in part, related to the reason the patient came to need home health care.

3) I certify that based on my findings, the following services are medically necessary for Home Health services. (Check all that apply)

- Skilled Nursing Speech Therapy Medical Social Work
Physical Therapy Occupational Therapy Home Health Aide

4) My clinical findings listed here support the need for the skilled services because:

Four horizontal lines for clinical findings.

5) I certify that my clinical findings support that this patient is homebound (Medicare definition of homebound = absences from home require considerable and taxing effort and are for medical reasons, or religious services, and/or state-certified adult daycare are disregarded (not counted). Absences for other reasons must be infrequent or of short duration) because:

Two horizontal lines for explanation of homebound status.

Physician Signature _____ Date of Signature _____

Physician Printed Name _____