UPMC Home Healthcare

☐ North Branch ☐ South Branch

☐ Horizon Branch

Home Health Referral Information

Patient Name: _____ **DOB:**_____

Diagnosis:

_____

Skilled Need:

_____

_____

Homebound due to:

_____

_____

Central Intake RN Signature:_____ **Date:**_____

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Home Health Physician Documentation of Face-to-Face Encounter

PLEASE COMPLETE <u>ALL SECTIONS</u> AND RETURN TO CENTRAL INTAKE:
FAX #: 724-778-4747

Patient Name: DOB:

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:

Date patient was seen: _____
Month Day Year

I certify that the following services are medically necessary home health services (Check all that apply):

_____Nursing
_____Physical therapy
_____Speech language pathology

Certification for Home Health services:
I certify that this patient is confined to the 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 initiated the establishment of the plan of care. This patient will be followed by a physician who will periodically review the plan of care.

Physician Signature: Date:

Physician Printed Name

FOR OFFICE USE ONLY

Admission #: _____ **Insurance:** _____

Document #: _____

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