UHHS United Home Health Services
A SERVICE OF GARDEN CITY HOSPITAL

Orders for Home Health Services / Attestation of Face-to-Face Encounter

Patient Name: _____ D.O.B: ___/___/___ Sex: ☐ M ☐ F

Physician Name: _____ Phone: _____ Fax: _____

Face-to-Face Encounter Date: ___/___/___

My clinical findings/patient's diagnoses support the need for home health services as follows: (Line #1)

_____

_____

_____

I certify my clinical findings support that this patient is **homebound** per CMS guidelines due to: (Line #2)

_____

_____

_____

The following services are medically necessary within 48 hours:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Home Health Aide ☐ Social Worker

I certify that the above named patient is under my care and that I, or the NPP working with me, had the face-to-face encounter fulfilling my requirement on the date identified above.

Signature of Physician: _____ Date: _____

Will the ordering /certifying physician oversee the Plan-of-Care (POC): ☐ YES ☐ NO

If not, please designate managing physician: _____ Phone: _____

***** Please include demographics page and up to date medication list * * ***

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United Home Health Services
6701 Harrison Road | Garden City, MI 48135
Office: (734) 981-8820 | Fax: (734) 458-6474 | UHHS.org