CPC Form

MR #:

Patient Name (Last, First)		Referral Date:	Referring Physician:	
Patient Address:		Phone:	Date of Birth:	SS#:
Sex: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ SEP	Reported By:	Reported To:	Start of Care:
Responsible Relative/Friend Name:	Address:		Phone:	Relationship:
Medicare No.	Medicaid No.	BCBS No.	Other Insurance:	
Hospital Admission Date:	Discharge Date:	Brief Medical History:		
Diagnosis(es):		Surgeries Performed:		

Medications:

Activities Permitted/Precautions:

Allergies:

Diet:

PHYSICIAN FACE TO FACE ENCOUNTER

I certify that this patient is under my care and that I, the physician, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter with this patient that meets the Medicare requirements for physician face-to-face encounter on:

Date: _____

I certify that the following information is based on the clinical findings of the visit:

The clinical findings support the need for skilled home health services (skilled nursing and/or therapy) for this patient because:

_____

_____

The clinical findings support that this patient is homebound* because:

_____

_____

**Homebound* is defined by Medicare as: Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or have a condition such that leaving his or her home is medically contraindicated. Also the patient must possess these qualities: there must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

SERVICES

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

Treatment:

_____

_____

_____

Goals:

_____

_____

_____

Additional Orders:

_____

_____

I certify that the above patient is under my care and request the above home health services. These professional services are to be provided on an intermittent basis and the established plan contained in the record will be reviewed by me at least every 60 days.

_____ _____

Physician Signature Date

_____ _____ _____

Physician Name Address City/Zip

_____ _____ _____

Phone Fax NPI