EQUITY SERVICES
of St. Paul, Inc.
AN EQUAL OPPORTUNITY EMPLOYER

Documentation of Face to Face Encounter for MEDICAID Patients

*****All fields on this form must be completed**
Please Fax to 651-489-4811 with medication list after encounter***

Name: Last, First MI	Date of Birth

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: (**Insert date that visit occurred**):

_____
Month Day Year

The face-to-face encounter must occur within 90 days prior to or 30 days after the initiation of home health services

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (**List medical condition and ICD-10**):

_____
_____
_____

I certify that, based on my findings, the following services are medically necessary home health services (**Check all that apply**):

- ❒ Nursing
- ❒ Home Health Aide
- ❒ Personal Care Assistant
- ❒ Homemaker

My clinical findings support the need for the above services because**: (list physical and/or cognitive findings)**

_____
_____
_____

Further, I certify that my clinical findings support that this patient's home is the most appropriate setting for services.

Physician Signature: _____ Date: _____

Physician Printed Name: _____

****Per Medicaid-If this form is completed by a NP or PA, it must also be signed by a physician**

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Home Care With A Heart