PHYSICIAN VISIT DOCUMENTATION FORM

This form must be completed by the Physician ordering home health services.

Date: _____

Medicaid Recipient's Name: _____

Physician's Name: _____

Physician's Address: _____

_____

Physician's Telephone Number: (_____) _____

Diagnosis(es): _____

Date of the recipient's last examination or consultation in your office: _____

Please describe the patient's ongoing need for home health services:

_____

_____

_____

_____

_____

_____

I hereby certify that I have examined the above named recipient on _____ and have ordered home health services to treat the recipient's acute or chronic medical condition as described above.

Signature of Physician: _____

National Provider Identifier: _____

Pursuant to 409.905 (4) (c), Florida Statutes: In order for Medicaid to reimburse for home health services, the physician ordering the services must have examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

After completion of this form, please send directly to the recipient's home health agency.