

SOC- PHYSICIAN'S ORDERS AND PLAN OF CARE

Last Name: First Name: To: Medco Home Health Care, Inc
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MR#:

ADDRESS OF CARE: *This document serves as the certifying physicians order for Home care for the identified patient. The HHA is being requested on the basis described below on the face to face encounter documentation under clinical findings, in support of medical condition and patient's homebound status.

Phone: Referral Date: SOC Date:

Date of Birth: Gender: M F Medicare No:

Responsible Family/ Friend: Medicaid No:

Relationship: Other Insurance:

Phone: Hospital Admission Date: DC date: Name Of Hospital:

FACE TO FACE ENCOUNTER DOCUMENTATION

Face to Face Eligible Encounters: Institutional Provider conducted face to face encounter: Home Health Physician Certifying: Conducted face to face in last 90 days of SOC: Will have face to face encounter within 30 days of after SOC: (Agency or physician to complete)

PHYSICIAN ATTESTATION

This encounter with the patient was directly related to the following medical condition(s) which is/are the primary reasons for home care. List Diagnosis:

Prognosis: Good Fair Poor (circle one) Surgery performed and date:

CLINICAL FINDINGS

My clinical findings support the need for home care services because:

I certify that this patient is under my care and that I, a nurse practitioner or physician assistant or qualified practitioner working with me had a face-to-face encounter that meets the physician face-to-face encounter requirements with patient on: (Date visit occurred)

I certify that, based on my findings, the following home health services are medically necessary for this patient and they will evaluate for: SN PT OT HHA MSW SLP RD Other:

(Please check all that that apply)

I further certify that my clinical findings support that this patient is homebound because: Residual weakness Requires maximum assistance/taxing effort to leave home confusion/unable to safely leave home Severe SOB/SOB exertion Unable to leave home unassisted Any other clinical factors that affect homebound status: (list)

Medications: See medication list in home Lab Orders: Diet Activity Restrictions: Wound/Dressing Tx:

Physician Name: NPI#

Address:

Phone: Fax:

V.O. Date

Physician Signature: Date: