Patient Name _____ Date of Birth_____/_____/_____

VNSNY MRN _____ Case No _____

Hospital/Institution_____ Record_____

MEDICARE PRIMARY INSURANCE

CERTIFICATION STATEMENT FOR HOME HEALTH SERVICES UNDER MEDICARE BENEFIT

CHOOSE ONE:

☐ I am certifying for **Medicare** home health services and plan to supervise the patient's home health services in the community.

OR

☐ I am certifying for **Medicare** home health services but will not be following the patient in the community.

The patient's community physician is

_____M.D.

CERTIFICATION MUST BE SIGNED BY A MEDICARE PECOS ENROLLED PHYSICIAN

CERTIFICATION STATEMENT:

I am a Medicare PECOS enrolled physician and I certify that:

This patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, and additionally may need occupational therapy. The patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health, and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

_____/_____/_____.

_____M.D.
Physician Signature

Date _____/_____/_____.

_____M.D.
Printed Name

MEDICAID PRIMARY INSURANCE

CERTIFICATION STATEMENT FOR HOME HEALTH SERVICES UNDER MEDICAID BENEFIT

CHOOSE ONE:

☐ I am certifying for **Medicaid** home health services and plan to supervise the patient's home health services in the community.

OR

☐ I am certifying for **Medicaid** home health services but will not be following the patient in the community.

The patient's community physician is

_____M.D.

CERTIFICATION MUST BE SIGNED BY A MEDICAID OPRA ENROLLED PHYSICIAN

CERTIFICATION STATEMENT:

I am an OPRA enrolled physician and I certify that:

This patient needs nursing care, physical therapy and/or speech therapy and additionally may need occupational therapy that is medically necessary. This patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health, and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

_____/_____/_____.

_____M.D.
Physician Signature

Date _____/_____/_____.

_____M.D.
Printed Name

PLEASE FAX THIS FORM TO: 212-290-3939