VNS Health

HOME CARE

Patient Name _____

Date of Birth _____ /_____ /_____

VNS Health MRN _____ Case No. _____

Hospital/Institution _____ Record No. _____

Medicare Primary Insurance

Certification statement for VNS Health Home Care services under Medicare benefit

Choose One:

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

Or

I am certifying for **Medicare** home care 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 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 care, and was related to the primary reason the patient requires home care services; the encounter was performed by a physician or allowed non-physician practitioner on

_____ /_____ /_____ .
Face-to-Face Encounter Date

_____ M.D.
Physician Signature

Date _____ /_____ /_____ .

_____ M.D.
Printed Name

Medicaid Primary Insurance

Certification statement for VNS Health Home Care services under Medicaid Benefit

Choose One:

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

Or

I am certifying for **Medicaid** home care 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 a Medicaid OPRA enrolled physician and I certify that:

This patient needs nursing care, physical therapy and/or speech therapy, and 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 care, and was related to the primary reason the patient requires home care services; the encounter was performed by a physician or allowed non-physician practitioner on

_____ /_____ /_____ .
Face-to-Face Encounter Date

_____ M.D.
Physician Signature

Date _____ /_____ /_____ .

_____ M.D.
Printed Name

Please fax this form to: 212-290-4688