UNITED AMERICA
HOME HEALTH

IN ADDITION TO THIS, PLEASE INCLUDE:
Demographics / Patient's Face Sheet
Progress Notes and/or Last Clinic Visit Notes

Home Health Referral / Face to Face Form

Patient's Name: _____ **DOB:** _____

I certify that the above-named patient is under my care and that I, or the allowed practitioner working with me, fulfilled the required face-to-face encounter on the date below.

Face To Face Encounter Date: _____

The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was:

1: _____

2: _____

3: _____

I believe that based on my clinical findings, the patient is homebound and the following home health services are medically necessary:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy
☐ Speech Therapy ☐ Medical Social Worker ☐ Home Health Aide

Further, I certify that my clinical findings support that this patient is homebound (i.e absence from home requires considerable and taxing effort and are for medical reasons or religious services or are infrequent or of short duration when for other reasons) because:

_____

_____

_____

_____ _____
Physician's Signature: **Date:**

_____ _____
Physician's Printed Name: **NPI:**

PHONE 713-975-1310 **FAX** 713-975-7312 **EMAIL** Intake@Unitedamericahealth.com
3721 Briarpark Dr #155, Houston, TX 77042