Phoenix Home Care LLC

Fax Number 630-654-5705

Attn: Intake Department

Certification of Eligibility for Medicare/Medicare Advantage Home Health Services

I hereby certify that _____meets the eligibility requirements

(Patient Name)

To receive home health services under the Medicare Program, including:

- Home health services are needed because the patient is confined to the home as defined in CMS Pub. 100-02, Ch. 7, Section 30.1.
- The patient needs skilled nursing or therapy services.
- A plan of care has been or will be established that will be reviewed by a physician and/or nurse practitioner.
- The services are or will be furnished when the patient is or was under the care of a physician and/or nurse practitioner.

A face-to-face encounter was conducted with the patient above on _____ by:

(Date)

- The undersigned physician, OR
- The undersigned nurse practitioner

_____ _____

(Physician and/or nurse practitioner signature and credentials) (Date)

_____ I am the physician and/or nurse practitioner working in a hospital or nursing home setting. The following physician will oversee the patient's post-discharge care.

_____ _____

(Physician Name) (Phone Number)