HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-10	Principal Diagnosis	Date
12. ICD-10	Surgical Procedure	Date
13. ICD-10	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received
Signed POT

24. Physician's Name and Address

26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

UnitedHealthcare COMMUNITY & STATE

ADDENDUM TO: ☐ PLAN OF TREATMENT ☐ MEDICAL UPDATE

1. Patient's HI Claim No.	2. Start of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Item No.	

9. Signature of Physician	10. Date

11. Optional Name/Signature of Nurse/Therapist	12. Date