Sumana Ketha M.D.
Board certified in Internal Medicine

DFW Medical Home PLLC
2925 Skyway Cir N, Irving, TX 75038
PH#: (972) 675-7313, FAX#: (972) 675-7310
Email: admin@texashousecalls.com

Agency Information: Agency Name: ____ Address: ____ City: ____ State: ____ Zip: ____ Phone: ____ FAX: ____ NPI: ____	**HOME HEALTH CERTIFICATION AND PLAN OF CARE** Order #:

Patient HI Claim No.	Start of Care Date	Certification Period	Medical Record No	Provider No

Patient Name, Address, and Phone Number	Attending Physician or Allowed Practitioner Name and Address
Prognosis	Allergies
Mental/Cognitive Status	Nutritional Requirements
Functional Limitations	Activities Permitted/Restricted
Safety	DME and Supplies
Advanced Directives	Caregiver Status

Psychosocial Status

Emergency Preparedness

Medications

ICD-10 CM Principal Diagnosis

Nurse/Therapist Signature And Date Of Verbal SOC Where Applicable	Date HHA Received Signed

Certifying Physician or Allowed Practitioner Name and Address

Physician or Allowed Practitioner Statement

I certify/re-certify that this patient is confined to his /her home (as outlined in section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual) and needs intermittent skilled nursing care, physical therapy, and /or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type on   and the encounter was related to the primary reason for home health care.

Physician or Allowed Practitioner Signature (Applies to total pages)	Signature Date

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Orders For Discipline and Treatment

Physician or Allowed Practitioner Signature (Applies to total pages)	Signature Date

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Goals

Physician or Allowed Practitioner Signature (Applies to total pages)	Signature Date

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Agency Information: Agency Name:______________________ Address:______________________ City:__________ State:__________ Zip:__________ Phone:__________ FAX:__________ NPI:__________	HOME HEALTH CERTIFICATION AND PLAN OF CARE Order #:
Rehabilitation Potential and Discharge Plan	
Homebound Narrative	
Medical Necessity	
F2F	
Other Physicians On The Case	
Optional Name/ Signature of Nurse/ Therapist	
Physician or Allowed Practitioner Signature (Applies to total pages)	Signature Date