

**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



<b>Agency Information:</b> Agency Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ FAX: _____ NPI: _____		<b>HOME HEALTH CERTIFICATION AND PLAN OF CARE</b> <b>Order #:</b> _____		
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				
<b>Physician or Allowed Practitioner Statement</b> 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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Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ NPI: \_\_\_\_\_

**HOME HEALTH CERTIFICATION AND PLAN OF CARE**  
**Order #:**

Goals

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