GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Durable Medical Equipment/Supplies Face-To-Face Encounter Certification

PATIENT NAME:	**D.O.B** ________/________/________ Month Day Year
Medicaid ID:	**Height ________ Weight________** **(if equipment is being replaced due to growth)**

Face to Face Encounter: I certify that this patient is under my care and that I (MD.DO or DPM), or a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS), had a face-to-face encounter with this patient on:

Date of Encounter: __________/__________/__________ Month Day Year **(The encounter must occur within six months <u>prior</u> to the order for equipment and/or supplies)**

The encounter with this patient was, in whole or in part, for the following medical condition, which is the primary reason the durable medical equipment and/or supplies is necessary:

List the primary medical condition that supports the medical necessity or the item(s) ordered:

I certify, that based on my findings, the following services are medically necessary:

List all items for which an order will be provided to a supplier of durable medical equipment: Equipment____ Supplies____

Attending Physician ________________________________ NPI__________________
Date____________

Also complete if the clinical professional is anyone other than the attending physician (PA, NP, or CNS):

Name/Credentials____________________________________ NPI
__________________ Date_____________

Please complete this form and provide it to the Durable Medical Equipment