GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Durable Medical Equipment/Supplies Face-To-Face (F2F) Encounter Certification

Patient Name:	**D.O.B.** _____/_____/_____ Month Day Year
Medicaid ID:	**Height**_____ **Weight**_____ **(If equipment is due to growth)**

Face to Face Encounter: I certify that this patient is under my care and that I (MD, DO, 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 prior 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:

_____

_____

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 Name:

_____

Address: _____ Phone:

_____

NPI _____Signature/Date:

_____

Provider:
Professional Medical HHC
404-292-9190
404-508-9225 Fax

or

Complete the information below if the clinical professional is anyone other than the attending physician (PA, NP, or CNS):

Name/Credentials: _____

Address: _____ Phone: _____