RI Medicaid
Documentation of Face-to-Face Encounter

Physician name: _____ NPI: _____

Patient Name: _____ Date of Birth: ____/ ____/ _____

MID: _____

For Durable Medical Equipment:

I certify that this patient is under my care and that I, or a PA, CRNP, or CNS, working with me, had a face-to-face encounter that meets the CMS face-to face encounter requirements with this patient within six (6) months prior to the date of prescription.

Face-to-Face Encounter Date _____ /_____/_____

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for the DME ordered.

Diagnosis: _____

I have evaluated the patient for the medical condition that supports the reason and need for each covered DME, appliance, or medical supply item prescribed below (List DME ordered):

_____

***Please Note**: A copy of the clinical visit note from the corresponding Face-to-Face encounter **MUST** be attached to this form. Orders cannot be filled without the attached documentation.

Physician Signature _____ Date_____/ _____/ _____