Face-to-Face (F2F) Encounter

Documentation of an F2F encounter is REQUIRED for patients to qualify for select Medicaid Services

PRESCRIPTION FOR SERVICES (FOR MEDICAID PATIENTS ONLY)

Qualified Physician & Non Physician Practitioner: Please complete the information below with the required patient information.

Patients name (*print*): ______________________________

Patients DOB: ______________________________

Encounter Date: ______________________________

***** Encounter date is the initial date when the physician or qualified non-physician practitioner performed the qualifying F2F encounter with the patient. *****

Check the services that will be ordered:

Home Health:	____________	ICD 10:	____________
DME:	____________	ICD 10:	____________
DMS:	____________	ICD 10:	____________
PT:	____________	ICD 10:	____________
ST:	____________	ICD 10:	____________
OT:	____________	ICD 10:	____________

***** Submit clinical documentation to support the initial F2F date *****

I Certify that the above information is true and correct based on my encounter with this patient. If I am not the community based physician, then I am certifying the need for services based on my contact with the patient.

Signature (MD, NP, PA or CNS): ______________________________

Name: (*printed*): ______________________________

Date: ______________________________

Please fax completed form to: 414-771-1159

For Questions please contact Trilogy Medical Management at: 414-755-3619 (Select Option 4 then Option 1)

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