

ADDENDUM TO: **PLAN OF CARE** **MEDICAL UPDATE**

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|---------------------------|-------------|--|-----------------------|-----------------|
| 1. Patient's HI Claim No. | 2. SOC Date | 3. Certification Period From: _____ To: _____ | 4. Medical Record No. | 5. Provider No. |
| 6. Patient's Name | | 7. Provider Name | | |

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|-------------|--|
| 8. Item No. | |
|-------------|--|

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| 9. Encounter Completed By - Name and Title | 10. Date Completed |
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11. Agency Narrative Summary (explain why patient qualifies for home health [why needed/homebound] and why is it needed now, include any devices/DMEs)

| | | |
|--|----------|----------|
| 12. Signature of Physician | 13. Date | 14. Time |
| 15. Optional Name/Signature of Nurse/Therapist | 16. Date | 17. Time |