CERTIFICATION AND RECERTIFICATION

(Skilled Nursing Facility)

PATIENT NAME _____ HIC/MBI NUMBER _____ ADMISSION DATE _____ FIRST SKILLED DAY _____

CERTIFICATION
of patient need for skilled care.

Required at time of admission/1st skilled day

I certify that SNF services are required to be given on an inpatient basis because of the above named patient's need for skilled nursing care on a daily basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME

RECERTIFICATION
of continued SNF inpatient care. **On or before the 14th day.**

Due no later than 14 days from Admission date/1st skilled day

I certify that continued SNF inpatient care is necessary on a daily basis for the following reason(s):

_____

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days or _____ weeks.

Plans for post-SNF care are: ❑ Home Health Agency ❑ Office Care ❑ Other _____

Continued SNF care is for same condition(s) for which patient received inpatient hospital services: ❍ Yes ❍ No

Date Due_____

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME

RECERTIFICATION
of continued SNF inpatient care.

Due no later than 30 days from the 1st recertification signature date (above)

I certify that continued SNF inpatient care is necessary on a daily basis for the following reason(s):

_____

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days or _____ weeks.

Plans for post-SNF care are: ❑ Home Health Agency ❑ Office Care ❑ Other _____

Continued SNF care is for same condition(s) for which patient received inpatient hospital services: ❍ Yes ❍ No

Date Due_____

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME

RECERTIFICATION
of continued SNF inpatient care.

Due no later than 30 days from the 2nd recertification signature date (above)

I certify that continued SNF inpatient care is necessary on a daily basis for the following reason(s):

_____

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days or _____ weeks.

Plans for post-SNF care are: ❑ Home Health Agency ❑ Office Care ❑ Other _____

Continued SNF care is for same condition(s) for which patient received inpatient hospital services: ❍ Yes ❍ No

Date Due_____

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME

RECERTIFICATION
of continued SNF inpatient care.

Due no later than 30 days from the 3rd recertification signature date (above)

I certify that continued SNF inpatient care is necessary on a daily basis for the following reason(s):

_____

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days or _____ weeks.

Plans for post-SNF care are: ❑ Home Health Agency ❑ Office Care ❑ Other _____

Continued SNF care is for same condition(s) for which patient received inpatient hospital services: ❍ Yes ❍ No

Date Due_____

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME

AMBULANCE SERVICE

I hereby certify that ambulance service was medically necessary for the above named patient.

_____ _____ _____ ❍ AM ❍ PM
PHYSICIAN SIGNATURE DATE TIME