PHYSICIAN CERTIFICATION and RECERTIFICATION
(Medicare)

CERTIFICATION
Of patient admission
Requirement at time of
admission.

_____
(PATIENT) (HEALTH INSURANCE CLAIM NUMBER)

_____
(ADMISSION DATE)

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

_____ _____
(PHYSICIAN) (DATE)

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

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

_____

_____

Date: _____

_____

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 (specify)

Continued SNF care is for same condition for which patient received inpatient hospital service:

_____Yes _____ No

_____ _____
(PHYSICIAN) (DATE)

2nd
RECERTIFICATION
of continued SNF inpatient
care. On or before the 30th day

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

_____

following first recertification _____

Date: _____

_____

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 (specify)

Continued SNF care is for same condition for which patient received inpatient hospital service:

_____Yes _____ No

_____ _____
(PHYSICIAN) (DATE)

3rd
RECERTIFICATION
of continued SNF inpatient
care. On or before the 60th day

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

_____

following first recertification _____

Date: _____

_____

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 (specify)

Continued SNF care is for same condition for which patient received inpatient hospital service:

_____Yes _____ No

_____ _____
(PHYSICIAN) (DATE)