Your Hospital's Logo Here

CERTIFICATION & RECERTIFICATION
(SKILLED NURSING FACILITY)

PATIENT | ADMISSION DATE | HEALTH INSURANCE CLAIM NUMBER

CERTIFICATION
of patient admission. Required at time of admission.

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 continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

PHYSICIAN | DATE

RECERTIFICATION
Of continued SNF in-patient care. **On or before the 14th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

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 for same condition(s) for which patient received inpatient hospital services:
☐ YES ☐ NO

Date Due _____

PHYSICIAN | DATE

RECERTIFICATION
Of continued SNF in-patient care. **On or before the 44th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

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 for same condition(s) for which patient received inpatient hospital services:
☐ YES ☐ NO

Date Due _____

PHYSICIAN | DATE

RECERTIFICATION
Of continued SNF in-patient care. **On or before the 74th day.**

I certify that continued SNF inpatient care is necessary for the following reasons.

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 for same condition(s) for which patient received inpatient hospital services:
☐ YES ☐ NO

Date Due _____

PHYSICIAN | DATE

AMBULANCE SERVICE:

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

PHYSICIAN | DATE