CERTIFICATION AND 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) (TIME & DATE)

RECERTIFICATION of continued SNF inpatient care. On or before the 14th day.
(Due no later than 14 days from Admission date)
I certify that continued SNF inpatient care is necessary for the following reason(s):

Date Due __________
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

(PHYSICIAN) (DATE)

RECERTIFICATION of continued SNF inpatient care.
Due no later than 30 days from the previous recertification signature date
I certify that continued SNF inpatient care is necessary for the following reason(s):

Date Due __________
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

(PHYSICIAN) (DATE)

RECERTIFICATION of continued SNF inpatient care.
Due no later than 30 days from the previous recertification signature date
I certify that continued SNF inpatient care is necessary for the following reason(s):

Date Due __________
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

(PHYSICIAN) (DATE)

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

(PHYSICIAN) (DATE)

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