## RESIDENT NAME (Last, First, Middle)

<table>
<thead>
<tr>
<th>HEALTH INSURANCE CLAIM NUMBER</th>
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### 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 and/or skilled rehabilitation care on a continuing basis.

- MDS assessment date (Section A3a) ______________
- RUG III code (MDS Section T3) ______________
- I certify that the RUG III category calculated on this resident’s MDS assessment is appropriate.

- (PHYSICIAN) ____________________
- (DATE) ________________

### RECERTIFICATION

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

- Date Due __/__/______
- I certify that continued SNF inpatient care is necessary for the following reason(s):

- (PHYSICIAN) ____________________
- (DATE) ________________

#### of continued SNF inpatient care. On or before the 44th day.

- (Due no later than 30 days from the previous recertification signature date)
- Date Due __/__/______
- I certify that continued SNF inpatient care is necessary for the following reason(s):

- (PHYSICIAN) ____________________
- (DATE) ________________

#### of continued SNF inpatient care. On or before the 30 days following the previous certification.

- Date Due __/__/______
- I certify that continued SNF inpatient care is necessary for the following reason(s):

- (PHYSICIAN) ____________________
- (DATE) ________________

### AMBULANCE SERVICE

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

- (PHYSICIAN) ____________________
- Reason: ____________________________________________
- (DATE) ________________