Physician Certification – Recertification for Medicare Part A

Patient Name	Date Admitted to Medicare	Physician
Ima Patient	7/23/2023	Dr. Geriatrician

Initial CERTIFICATION

at time of admission.

7/23/2023

Admission Date

I certify that post-hospital SNF services as a practical matter are required to be given on an inpatient basis because of the above-named resident's need for daily skilled nursing care and/or daily skilled rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving hospital services prior to his/her transfer to the SNF.

Dr. Geriatrician — 7/24/23

Physician's or NPP Signature — *Date*

First RECERTIFICATION of continued SNF inpatient care.

On or before the 14th day of admission

8/5/2023

Date

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

COPD, pneumonia, DMII - OT / PT to address ambulation & self-care performance / safety in order to return home with spouse at PLOF. Nursing for assessment and management of the care plan with daily oxygen therapy.

I estimate that the additional period of SNF inpatient care will be 30 days (or ______ weeks).

Plans for post-SNF care are: ☒ Home Health Agency ☐ Office care ☐ Other (specify) ____________________________

Continued SNF care is for same condition(s) for which patient received inpatient hospital services, OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services. ☒ Yes ☐ No

Dr. Geriatrician — 8/3/23

Physician's or NPP Signature — *Date*

Second RECERTIFICATION of continued SNF inpatient care.

On or before the 30th day after date of previous Physician recertification.

9/2/2023

Date

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

COPD, DMII - OT/PT for balance, gait, ADLs, IADLs to return home at PLOF. Nursing for teaching and training / safe transition planning.

I estimate that the additional period of SNF inpatient care will be 30 days (or ______ weeks).

Plans for post-SNF care are: ☒ Home Health Agency ☐ Office care ☐ Other (specify) ____________________________

Continued SNF care is for same condition(s) for which patient received inpatient hospital services, OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services. ☒ Yes ☐ No

Dr. Geriatrician — 9/1/23

Physician's or NPP Signature — *Date*

Third RECERTIFICATION of continued SNF inpatient care.

On or before the 30th day after date of previous Physician recertification.

10/1/2023

Date

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

Discharge home with home health on 9/12/23

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(s) for which patient received inpatient hospital services, OR for a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services. ☐ Yes ☐ No

Physician's or NPP Signature — *Date*