**Physician Certification – Recertification for Medicare Part A**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date Admitted to Medicare</th>
<th>Physician</th>
<th>Health Insurance Claim Number (Medicare #)</th>
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</thead>
</table>

### CERTIFICATION
Of a patient admission.

I certify that SNF services are required to be given on an inpatient basis because of the above named patient’s needs for skilled nursing care on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to he/she was receiving inpatient hospital services prior to his/her transfer to the SNF. The patient’s current needs for skilled coverage includes: ____________________________________________________________________________.

**Required at time of admission**

<table>
<thead>
<tr>
<th>Physician’s Signature</th>
<th>and</th>
<th>Date</th>
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### RECERTIFICATION
of continued SNF inpatient care.

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

On or before the 14th day following admission

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)

May be completed at time of admission

Continued SNF care is for same condition(s) for which patient received inpatient hospital services.

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### RECERTIFICATION
of continued SNF inpatient care.

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

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

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) which patient received inpatient hospital services.

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### RECERTIFICATION
of continued SNF inpatient care.

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

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

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) which patient received inpatient hospital services.

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