FACILITY _____ ADDRESS _____

Resident Name	Health Insurance Claim Number	Admission Date

CERTIFICATION
of resident admission.
Required at time of
admission.

I certify that Post-Hospital SNF Services are required to be given on an in-resident basis because of the above-named resident's need for skilled nursing care on a continuing basis for the condition(s) for which he was receiving in-resident hospital services prior to his transfer the the SNF.

Signature of Physician _____ Date _____

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CERTIFICATION