FACILITY _____ ADDRESS _____

Resident Name	Health Insurance Claim Number	Admission Date

RECERTIFICATION of continued SNF in-resident care. Sign on or before _____ day.

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

_____

_____

_____

I ESTIMATE THAT THE ADDITIONAL PERIOD OF SNF IN-RESIDENT CARE WILL BE ____ DAYS (OR ____ WEEKS). CONTINUED SNF CARE IS FOR SAME CONDITION FOR WHICH RESIDENT RECEIVED IN-RESIDENT HOSPITAL SERVICES:
☐ YES ☐ NO

PLANS FOR POST-SNF CARE ARE: ☐ Home Care ☐ Office Care ☐ Facility Care
☐ OTHER (specify) _____

If not signed within 14 days, give reason for delay _____

_____

Signature of Physician Date

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RECERTIFICATION