



Skilled Nursing Facility Certification and Re-Certification 3-Day Qualifying Hospital Stay Waiver Utilized

Patient: _____

Admission Date: _____

Health Insurance Claim Number: _____

Certification on Admission

Admit to Medicare Part A Certified Level of Care. 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 would have received inpatient hospital services for 3 days prior to the stay if not prevented by the declared Public Health Emergency.

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Time and Date)

Re-Certification

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

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

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):

Due Date _____

Continued SNF care is for the same condition(s) for which the patient would have received inpatient hospital services:

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Date)

Re-Certification

of continued SNF inpatient care. **30 Days from previous re-certification date.**

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

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):

Due Date _____

Complete only after previous re-cert signed

Continued SNF care is for the same condition(s) for which the patient would have received inpatient hospital services:

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Date)

Ambulance Services

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

(Physician's Signature)

(Date)

Skilled Nursing Facility Re-Certification 3-Day Qualifying Hospital Stay Waiver Utilized Use Only After Page 1 is Completed

Patient: _____

Admission Date: _____

Health Insurance Claim Number: _____

Re-Certification
of continued SNF inpatient
care. **30 Days from previous
re-certification date.**

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

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):

Due Date _____
Complete only after previous
re-cert signed

Continued SNF care is for the same condition(s) for which the patient would have received
inpatient hospital services:

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence
which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Date)

Re-Certification
of continued SNF inpatient
care. **30 Days from previous
re-certification date.**

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

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):

Due Date _____
Complete only after previous
re-cert signed

Continued SNF care is for the same condition(s) for which the patient would have received
inpatient hospital services:

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence
which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Date)

Re-Certification
of continued SNF inpatient
care. **30 Days from previous
re-certification date.**

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

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):

Due Date _____
Complete only after previous
re-cert signed

Continued SNF care is for the same condition(s) for which the patient would have received
inpatient hospital services:

Yes No

Was Re-Certification Timely?

Yes No If No, provide an explanation for the delay and any medical or other evidence
which the SNF considers relevant for the purposes of explaining the delay:

(Physician's Signature)

(Date)