PROGRAM RECERTIFICATION

RECERTIFICATION:
of continued SKILLED inpatient care. On or before the 14th day. Date: _____

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

_____

_____

_____

I estimate that the additional period of Skilled inpatient care will be _____ days.
Plans for post-Skilled care are: ☐ Home Health Agency ☐ Office Care ☐ Nursing Home
☐ Other (specify): _____

Continued Skilled care is for same condition which arose after transfer while patient was still in the Skilled for treatment of a condition for which he/she received inpatient hospital services. ☐ Yes ☐ No

Physician _____ Time and Date _____

2nd
RECERTIFICATION:
On or before the 44th day. Date: _____

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

_____

_____

_____

I estimate that the additional period of Skilled inpatient care will be _____ days.
Plans for post-Skilled care are: ☐ Home Health Agency ☐ Office Care ☐ Nursing Home
☐ Other (specify): _____

Continued Skilled care is for same condition which patient received inpatient hospital services: ☐ Yes ☐ No

3rd
RECERTIFICATION:
On or before th 74th day. Date: _____

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

_____

_____

_____

I estimate that the additional period of Skilled inpatient care will be _____ days.
Plans for post-Skilled care are: ☐ Home Health Agency ☐ Office Care ☐ Nursing Home
☐ Other (specify): _____

Continued Skilled care is for same condition which patient received inpatient hospital services: ☐ Yes ☐ No

Continued Skilled care is for same condition which arose after transfer while patient was still in the Skilled for treatment of a condition for which he/she received inpatient hospital services. ☐ Yes ☐ No

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A Ministry of the Sisters of Charity Health System