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

Harmony Healthcare INTERNATIONAL

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)

Harmony Healthcare INTERNATIONAL

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)