

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.
6. Patient's Name			7. Provider's Name	
8. Medicare Covered: <input type="checkbox"/> Y <input type="checkbox"/> N	9. Date Physician Last Saw Patient: _____		10. Date Last Contacted Physician: _____	
11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Do Not Know	12. <input type="checkbox"/> Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Modified			

13. Specific Services and Treatments

Discipline	Visits (This Bill) Rel. to Prior Cert.	Frequency and Duration	Treatment Codes	Total Visits Projected This Cert.

14. Dates of Last Inpatient Stay: Admission _____ Discharge _____	15. Type of Facility _____
16. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline	

SAMPLE

17. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status _____

18. Supplementary Plan of Treatment on File from Physician Other than Referring Physician: Y N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

19. Unusual Home/Social Environment _____

20. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable	21. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence
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22. Nurse or Therapist Completing or Reviewing Form	Date (Mo., Day, Yr.)
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