SAMPLE FOR CERTIFICATION FORM – use obs and inpt to fix both

Affix Chart Sticker

USE FOR ALL PAYERS – EVERY TIME, EVERY TIME

USE THIS SIDE FOR MEDICARE ONLY

Date/ Time	Patient Status	INPATIENT ADMISSION CERTIFICATION/MEDICARE ONLY
	Date of Service:	Must be completed by provider for Inpatient Admissions
	Check appropriate box for patient status:	This patient is admitted for inpatient services. The patient is medically appropriate and meets medical necessity for inpatient admission in accordance with CMS section 42 C.F.R §412.3. I reasonably expect the patient will require inpatient services that span a period of time over two midnights. My rationale for determining that inpatient admission is necessary is noted in the section below. Additional documentation will be found in progress notes and admission history and physical.
	☐ **Place in Outpatient Observation** Diagnosis:_____ **Reason** for Placement: _____	**Primary Diagnosis**:_____ **Expected Length of Stay: (MEDICARE ONLY)** **Select One:** ☐ 2 Midnights (MN) Inpatient ☐ 1 MN Outpatient (ER , recovery or Obs) and 1MN Inpatient **For Initial Certification (CAH only)** ☐ I Expect the Length of Stay to Not Exceed 96 hrs **For Re-Certification** ☐ The Length of Stay is Exceeding 96 hrs
	☐ **Admit to Inpatient Services** (Medical) *PROVIDER MUST COMPLETE CERTIFICATION* **Diagnosis:** _____ **Reason** for Admission/PLAN attached to the reason for the 2 MN stay: _____ _____	**Plans for Post-Hospital Care:** See Discharge plan/signed prior to discharge **Supportive Findings to Primary Diagnosis:** [examples: co-morbidities, abnormal findings, diagnostic abnormalities, exacerbations, new onset of disease with_____(co-morbidities)] **NOTE: NEED A CLINICAL REASON/CONTINUED PLAN FOR WHY BEYOND 96 HRS?** _____ _____ _____ _____ _____ _____ _____
	Attending Provider (Print Name) (Note: if the ER provider does not have 'admitting privileges, only transitional privileges", important that this include a statement: Spoke with the admitting/attending_____, and we concur with the admission status." ER provider signs.	
	PCP (Print Name)	
	PCP (Print Name) **Provider Signature**	
	Provider Signature **Date/Time**	**Certifying Provider Signature (this 2nd signature required for inpatient admissions as the provider who is directing care.)** **Date/Time**

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