**Physician Certification Page**
**(Used for requesting a LOC-Level of Care)**

**Facility Name:___________________________________________**

**Resident Name:__________________________________________**

**Date of Admission:__________________________________**
**(Not Readmission date) Admission= Resident resided in the community or another Medicaid certified NF prior to Admission; Readmission= Resident was residing in your NF prior to Readmission)**

**Medicaid #:_______________________________________________**

**Medicaid Effective Date:_________________________________**

**As attending physician, I have reviewed the information contained herein and certify that it is a true and accurate reflection of the resident's condition (at the time of vendor payment change).**

**I certify that the resident requires:**

___________________________________________________________
**Physician Signature** **Date**