



ICF/IID PHYSICIAN CERTIFICATION AND RECERTIFICATION
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES DIVISION
SFN 1812 (8-2017)

Federal regulation 42 CFR 456.360 requires that a physician certify the need for services in an intermediate care facility for each eligible recipient of Medical Assistance upon admission and at least every 365 days (may not exceed 365 days). This is to certify that the recipient named below requires, on an inpatient basis, ICF/IID level of care.

1. Complete the provider, recipient and certifying physician sections of the form.
2. Give this form to the certifying physician to sign.
3. Maintain the original signed copy in your agency file.
4. Form must be filled out upon admission to an ICF/IID and reviewed and updated annually after admission.
5. Developmental Disabilities Providers are required to submit institutional claims utilizing the certifying physician information in the claim under the attending physician section.

DEVELOPMENTAL DISABILITY PROVIDER INFORMATION

Provider Name		Provider NPI	
Address	City	State	ZIP Code

RECIPIENT INFORMATION

Recipient Name	Certification Period (MM/DD/YYYY) From: _____ To: _____
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CERTIFYING PHYSICIAN INFORMATION

Certifying or Attending Physician Name		Physician NPI	
Address	City	State	ZIP Code

PHYSICIAN SIGNATURE Includes a Doctor of Osteopathy, physician's assistant or nurse practitioner acting within their scope of authority and under the direction of a physician)

Signature of Certifying or Attending Physician (must initial if using rubber stamp)	Date
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