# ICF/IID PHYSICIAN CERTIFICATION AND RECERTIFICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1812 (3-2023)

Clear Fields

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 DISABILITIES PROVIDER INFORMATION

| Provider Name | | Provider NPI | |
|---|---|---|---|
| Address | City | State | ZIP Code |

## RECIPIENT INFORMATION

| Recipient Name | Certification Period (MM/DD/YYYY) From: To: |
|---|---|

## 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)

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

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