

PERSONAL CARE
Physician Certification

This form must be in the member's file if the Pre-Admission Screening tool was completed by a Registered Nurse.

I have thoroughly reviewed the Pre-Admission Screening (PAS) for _____
Patient Name
completed by _____ on _____. I confirm the findings
RN Name Date
on the PAS correctly describes the physical and mental condition(s) of the above mentioned patient.

I understand my signature on this form and the PAS is certifying the information is complete and accurate. I understand that payment for the services based on the medical information contained on this form will be from Federal and State funds. Should it be proven that the medical information on this form is false, I understand that I may be charged with Medicaid Fraud.

Physician Name Printed (Must be M.D. or D.O.)

Physician Signature (Must be M.D. or D.O.)

Date