

McLaren Northern Michigan
BEHAVIORAL HEALTH
PHYSICIAN CERTIFICATE & RE-CERTIFICATION

Initial Certification

Due Date: ____/____/____

I certify that the inpatient psychiatric hospital admission was medically necessary for either:

____ treatment which could reasonably be expected to improve the patient's condition

OR

____ diagnostic study.

I estimate ____ days / ____ weeks of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are:

Attending or Staff Physician

Date

Time

Re-Certification

Day 12

Due Date: ____/____/____

I certify that the inpatient psychiatric facility services furnished since the previous certification were, and continue to be, medically necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study and that the hospital records indicate that the services furnished were, either, intensive treatment services, admission and related services necessary for diagnostic study, or equivalent service.

I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

I estimate ____ days / ____ weeks of hospitalization is necessary for proper treatment of the patient. My plans for post-hospital care for this patient are:

Attending or Staff Physician

Date

Time



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