Authorized Healthcare Provider Recertification Form

Section 1: Patient Information

Patient Name: _____

Date of Birth: _____

Patient ID/Account Number: _____

Section 2: Medical Certification

I hereby certify that I have examined the patient named above and reviewed their current medical status. Based on my clinical evaluation, I recommend the following:

Current Diagnosis/Condition: _____

Treatment/Service Recertification Period: From: _____ To: _____

Is the patient following the prescribed treatment plan? [ ] Yes [ ] No

Medical Necessity Statement:
_____
_____

Section 3: Healthcare Provider Information

Provider Name: _____

Title/Credentials: _____

License Number: _____

Facility/Clinic Name: _____

Phone Number: _____

Email Address: _____

Section 4: Signature

I certify that the information provided is true and accurate to the best of my knowledge.

Provider Signature: _____ Date: _____