State of New York
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

PHYSICIAN CERTIFICATION FOR INPATIENT SERVICES

PATIENT'S LAST NAME	FIRST	M.I.
CONSECUTIVE NO.	SEX. M [ ] F [ ]	
FACILITY	ADMISSION DATE	

I. PHYSICIAN'S ADMISSION CERTIFICATION FOR ALL PATIENTS

I certify that the patient has a diagnosis of alcohol or substance dependence, is free of serious communicable disease, and has no condition requiring care in an acute care hospital.

Physician's Signature _____ Date _____

II. ADMISSION CERTIFICATION OF A MEDICAID RECIPIENT

Initial Certification at Admission of a Medicaid Recipient

Mo. Day Yr.

I certify that inpatient facility services are required for treatment of alcohol or substance dependence based on the criteria specified in 14 NYCRR 381.4 (c) (3).

Physician's Signature _____ Date _____

III. CERTIFICATION AT THE TIME OF MEDICAID APPLICATION

Certification upon Medicaid Application

Mo. Day Yr.

I certify that inpatient facility services are required for treatment of alcohol or substance dependence based on the criteria specified in 14 NYCRR 381.4 (c) (3).

Physician's Signature _____ Date _____

IV. FIRST RECERTIFICATION OF NEED FOR CARE OF A MEDICAID PATIENT

Recertification no later than the 60th Day after Admission

Mo. Day Yr.

I certify that inpatient facility services continue to be required for treatment on alcohol or substance dependence based on the criteria specified in 14 NYCRR 381.4 (k) (2).

Physician's Signature _____ Date _____

V. SECOND RECERTIFICATION OF NEED FOR CARE OF A MEDICAID PATIENT

Recertification no later than the 120th Day after Admission

Mo. Day Yr.

I certify that inpatient facility services continue to be required for treatment based on the criteria specified in 14 NYCRR 381.4 (k) (2).

Physician's Signature _____ Date _____