Department of Health and Human Services
Health Care Financing Administration

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name

8. Medicare Covered: ☐Y ☐N	9. Date Physician Last Saw Patient:	10. Date Last Contacted Physician:

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N ☐ Do Not Know	12. ☐ Certification ☐ Recertification ☐ Modified

13. Dates of Last Inpatient Stay: Admission Discharge	14. Type of Facility:

15. Updated Information: New Orders/Treatment/Clinical Facts/Summary from Each Discipline

16. Functional limitations (Expand from 485 and Level of ADL) Reason Homebound/Prior Functional Status

17. Supplementary Plan of Care of File from Physician Other than Referring Physician: ☐Y ☐N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

18. Unusual Home/Social Environment

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if ascertainable	20. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

21. Nurse or Therapist Completing or Reviewing Form	Date (Mo.. Day, Yr.)