TEXAS
Health and Human
Services

Form 2601
March 2020-E

Physician Certification

1. Applicant/Member Name (Last, First, Middle Initial)	2. Medicaid or Applicant Social Security No.	3. Date of Birth
4. Applicant/Member Primary Diagnosis		
5. Other Active Diagnoses		

6.a. I have personally examined this individual in the last twelve months and reviewed all appropriate medical records. ◯ Yes ◯ No

6.b. **I certify that this individual requires ongoing nursing services under the supervision of a Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO). These services may be provided in either a home or community-based setting or in a nursing facility.** ◯ Yes ◯ No

I understand I am not prescribing nursing or other Medicaid services. By signing this form, I certify that the information provided above is accurate.

Signature of Physician	Date of Physician Signature
MD/DO License Number	MD/DO License State
MD/DO Name	Military Physician