 **Physician Certification**

**Form 2601**

March 2020-E

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| 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 an 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 Name | | MD/DO License Number | |
| MD/DO License State | | Military Physician | |