

Attachment. NFSS Therapist, Referring Physician and NF Administrator Therapy Signature Page

To be completed by respective parties, as applicable, and uploaded by NF if Type of Service is Therapy or Therapy Assessment Only.

Select Therapy (Select only one): Occupational Therapy Physical Therapy Speech Therapy

Therapist Signature

Therapist signature required to be completed by the licensed professional who completed the assessment regardless of the authorization type. The signature date indicates the date the authorization request was completed.

E0200A./E3200A./E6200A.

Therapist's First Name (Printed)

Therapist's Signature

E0200B./E3200B./E6200B.

Therapist's Last Name (Printed)

E0800./E3800./E6800. Therapist's Signature Date

Referring Physician Certification

To be completed by the Physician if Authorization Type is New or Restart.

Skip if Authorization Type is Assessment Only or Recertification.

Signature by the physician indicates that they certify the need for the services furnished under the treatment plan and while under their care.

E2000A./E5000A./E8000A.

Physician's Last Name

Physician Signature

E2000F./E5000F./E8000F. Physician's Signature Date

NF Administrator Acknowledgement

To be completed by NF Administrator if Type of Service is Therapy.

I acknowledge that I have been made aware of the resident's therapy request. I understand that appropriate facility staff or a contract therapist provided the assessment information that is included in this request to support the resident's need for requested therapy.

NF Administrator's First Name (Printed)

NF Administrator's Signature

NF Administrator's Last Name (Printed)

NF Administrator's Signature Date