Coastal
Health Systems of Brevard
ALS, BLS, SCT

DATE:

PATIENT:

DATE OF CALL:

FACILITY:

Please check the appropriate statement. Fax this completed form to 321-633-8504 Attention: Lisa Savary, Billing Director immediately.

_____ A. I certify that the above patient is a Medicare Part A patient and is **NOT** within his/her 100 days on the PPS System.

_____ B. I certify that the above patient is a Medicare Part A patient and **IS** within his/her 100 days on the PPS System.

_____Facility Admission Date.

Signature of Administrator:_____Date:_____

Revision Date 6/15/2010

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Rockledge, FL 32955
Visit us at: www.coastalhealth.org

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Communications: *(321) 631-1448*
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