Appendix 7

HCFA-487 Form

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

ADDENDUM TO: ☐ **PLAN OF TREATMENT** ☐ **MEDICAL UPDATE**

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

6. Patient's Name	7. Provider Name

8. Item No.

9. Signature of Physician	10. Date

11. Optional Name/Signature of Nurse/Therapist	12. Date

Form HCFA-487 (C4) (4-87) **PROVIDER**

Appendix