Hospice Recipient Election/Cancellation/Discharge Notice

(BHSF Form Hospice)

Form submitted for the Initial election of hospice services.

Medicaid Program
Hospice Recipient Election/Cancellation/Discharge Notice

TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

I elect to receive Hospice from the provider named below effective______________________
Admission Date

PATIENT'S DECLARATION

I understand and acknowledge:

- Medicaid Hospice consists of the following election periods:
- An initial 90-day period; A subsequent 90-day period;
- Subsequent periods of 60 days each. (Must be prior approved.)
- If I reach a point of stability in my terminal illness and am no longer considered declining in health and the Hospice is unable to certify me, I will return to the traditional Medicaid services, if applicable.
- By electing Medicaid Hospice, I waive all rights to Medicaid covered services related to the treatment of my terminal illness(es) and related conditions.
- If I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with Medicaid Hospice.
- By this election, I have been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to my terminal illness(es).

______________________ Signature of Patient or Legal Representative

______________________ Date signed

______________________ Legal Representative's Relationship to Patient

______________________ Representative Daytime Phone Number

TO BE COMPLETED BY HOSPICE PROVIDER

______________________ Type of Bill

______________________ FROM THROUGH
Statement Covers Period

______________________ Patient's Name

______________________ Patient's Medicaid ID Number

______________________ Patient's Address

______________________ Patient's Date of Birth

______________________ Patient's Medicare Number

______________________ Principal Diagnosis Code

______________________ List All Other Diagnosis Codes

______________________ Hospice Name and Address

______________________ Provider Number

______________________ Attending Physician ID & Name

______________________ Other Physician ID

______________________ Name of Nursing Facility or ICF-MR

______________________ Provider Representative Signature

______________________ Date Signed

BHSF Form Hospice
Reissued 08/2008 Prior Issue Obsolete

This form may <u>not</u> be altered.

CERTIFICATE OF Terminal Illness

(BHSF Form Hospice-TI)

Form submitted for the Initial election of hospice services

Provider will submit this form when a verbal election is received. This occurs when a physician doesn't sign the certificate of terminal illness form.

It is sent a second time when the physician(s) sign the form.

Medicaid Hospice Program
Certification of Terminal Illness

Patient's Name ____________ Patient's Medicaid ID Number ____________ Patient's Date of Birth ____________

First Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Attending Physician ____________ Signature of Hospice Medical Director or physician member of interdisciplinary group ____________

Date signed ____________ Date signed ____________

Second Benefit Period (90 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group ____________ Date signed ____________

Third Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group ____________ Date signed ____________

Fourth Benefit Period (60 days):
Having reviewed this patient's care and course of his/her illness, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

Signature of Hospice Medical Director or physician member of interdisciplinary group ____________ Date signed ____________

Note: If additional periods are to be certified use an additional form

VERBAL VERIFICATION (within two days of election date)

I certify that on the date signed below a verbal verification was obtained from the physician named below, confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

Physician's Name ____________ Terminal diagnosis(es) ____________

Name of IDG member taking referral ____________ Signature of IDG member taking referral ____________ Date signed ____________