

Medicaid Hospice Care Notification Form
Election, Revocation, Change in Designated Hospice, Death

Please Check All Appropriate Boxes

- Election of Medicaid Hospice
 Recipient also has Medicare
 If recipient has Medicare, recipient has elected the hospice benefit under Medicare
 Recipient is covered under another insurance with a hospice benefit

List Insurance: _____

- Revocation of Medicaid Hospice
 Recipient also has Medicare

Change in Designated Hospice

Date of Death: _____

Effective Date of Election of Hospice Care Benefit (per provider's election form): _____

Start date of Medicaid Hospice Care Benefit by Hospice Provider: _____

Provider Information

Hospice Designated by Recipient: _____ Medicaid Provider Number: _____

Address: _____

Phone Number: _____

Attending Physician: _____

Name of Nursing Facility in which Recipient Resides (if applicable): _____

Recipient Information

Name of Recipient: _____ D.O.B.: _____

Address: _____

Diagnosis: _____ Medicaid Number: _____

Prognosis: _____

Name of Agent or Legal Guardian (if applicable): _____

Hospice Benefit Information Election Period (circle one)

1st Period (90 days) 2nd Period (90 days) Unlimited number of 60 day periods:

1st 60 days 2nd 60 days 3rd 60 days 4th 60 days

Change in Designated Hospice

Effective Date: _____

Name of Current Hospice: _____ Phone: _____

Address: _____

Name of New Hospice: _____ Phone: _____

Address: _____

Revocation of Hospice

Effective Date of Revocation: _____

Date Eligible for Future Hospice Benefit: _____