MEDICAID HOSPICE ELECTION FORM

INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS

EFFECTIVE DATE:

RECIPIENT INFORMATION:

NAME: LAST FIRST			MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:
HOME PHONE NUMBER:	BIRTH DATE:		

For dates of service on or before September 1, 2015: ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	**For dates of service on or after October 1, 2015:** ICD-10 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::	MEDICAID PROVIDER NUMBER OF NURSING FACILITY:
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:	SEX: MALE / FEMALE

HOSPICE PROVIDER INFORMAITON:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:
ATTENDING PHYSICIAN'S NAME:	PHYSICIAN'S MEDICAID PROVIDER NUMBER:

HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

( ) FIRST 90 DAYS ( ) SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

ELECTION STATEMENT

- The South Carolina Medicaid Hospice Benefit program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the election statement.
- I understand that by signing the election statement, I am waiving all rights to regular Medicaid services except for payment to my attending physicians, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.
- I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefits periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.
- I understand that I may revoke the hospice benefits at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date; however, that if I choose to revoke services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.
- I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received and elect a new hospice provider.
- I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.
- I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

SIGNATURES:

RECIPIENT OR RECIPIENT REPRESENTATIVE SIGNATURE / DATE:	WITNESS SIGNATURE / DATE:

NOTE: This form must be forwarded to the SCDHHS Medicaid Hospice Program within ten (10) days of election of benefits for dually eligible recipients and fifteen (15) days for Medicaid only recipients. Failure to submit this form within that time frame will results in a change of the election date to the date this form is received by SCDHHS or KePRO.

MEDICAID HOSPICE PHYSICAN CERTIFICATION / RECERTIFICATION

RECIPIENT INFORMATION:			
NAME: LAST FIRST			MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:

HOME PHONE NUMBER (INCLUDE AREA CODE):	BIRTH DATE:
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::	MEDICAID PROVIDER NUMBER OF NURSING FACILITY:
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:	
For dates of service on or before September 1, 2015: ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	**For dates of service on or after October 1, 2015:** ICD-10 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:
NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR

PHYSICIANS, PLEASE SIGN AND DATE TO INDICTATE CERTIFICATION.

FIRST BENEFIT PERIOD (90 DAYS) DATES

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF ATTENDING PHYSICIAN	PHYSICIAN DATE SIGNATURE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATED SIGNATURE

SECOND BENEFIT PERIOD (90 DAYS) DATES

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATE SIGNATURE

_______ BENEFIT PERIOD (60 DAYS) DATES:

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	PHYSICIAN DATE SIGNATURE

NOTE: Forward a copy of this form and a copy of the plan of care within fifteen (15) working days along with the prior authorization request to KePRO. Failure to submit this form within the given time frame may result in delay or loss of payment for hospice service.

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

EFFECTIVE CHANGE DATE:_ _ _ _ _ _ _ _ _ _ _ _ _ _

APPLICABLE BENEFIT PERIOD:

_____FIRST 90 DAYS _____SECOND 90 DAYS _____PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME: LAST FIRST	SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:	MEDICARE NUMBER:

RELEASING HOSPICE PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed from:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The sending hospice must complete the above section. A copy of this form must be sent to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date and be forwarded to the receiving hospice within two (2) days of the effective date.

RECEIVING PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The receiving hospice must forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date.

SIGNATURES:

As a recipient of hospice services, I understand that I may change hospice providers only ONCE during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election benefit period.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
SIGNATURE OF WITNESS	DATE OF SIGNATURE

NOTE: Each hospice must maintain a copy of this Provider Change Request Form. It is the responsibility of the receiving hospice to forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date of the change for dually eligible recipients and within five (5) days to KePRO for Medicaid only recipients. Additionally for Medicaid only recipients, the KePRO Hospice Prior Authorization Form must be completed in conjunction with this form.

MEDICAID HOSPICE REVOCATION FORM

EFFECTIVE DATE OF REVOCATION:

APPLICABLE BENEFIT PERIOD:

( ) FIRST 90 DAYS ( ) SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME: LAST FIRST		SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:		MEDICARE NUMBER:

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

REVOCATION STATEMENT:

- **The South Carolina Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitation of the program and the terms of the revocation of these services.**
- **I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.**
- **I will forfeit all hospice coverage days remaining in this benefit period.**
- **I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.**

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:

NOTE: This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation for dually eligible recipients and five (5) working days to KePRO for Medicaid only recipients.

MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

NAME: LAST FIRST		SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:		MEDICARE NUMBER:

PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

DISCHARGE STATEMENT:

Hospice benefits for the above named recipient, enrolled with this agency since _____ terminated _____for the following reason: (check all that apply):

_____ Recipient is deceased. Date of death is _____/_____/_____.

_____ Prognosis is now more than six (6) months.

_____ Recipient moved out of state / service area.

_____ Safety of recipient or hospice staff is compromised. (Explanation must appear below)

_____ Recipient is non-compliant. (Explanation must appear below and documentation of efforts to counsel the recipient must be attached).

EXPLANATION:

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed above recipient has the right to a fair hearing regarding the decision. Procedures regarding that appeal are found on the reverse side of this page. The signature below indicates that the recipient was given this statement for his/her records/use.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:

NOTE: This form must be forward to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective of the discharge for dually eligible recipients and five (5) working days to KePRO for Medicaid only recipients.