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.