# Louisiana Medicaid Hospice Program

## RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

**PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY**

1. **Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting**

   - **Election/Admission Date (MM-DD-YYYY)**
   - **NOTE:** To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

### PATIENT'S STATEMENT

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better. I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

### SIGNATURES

- **Signature of Patient/Legal Representative**
- **Date of Signed (MM-DD-YYYY)**
- **Representative’s Daytime Phone # (incl. area code)**
- **Printed Name of Above Signee**
- **Legal Representative’s Relationship to Patient**

## PART II: TO BE COMPLETED BY HOSPICE PROVIDER

### PATIENT INFORMATION

- **Patient Name (First, Middle Initial, Last)**
- **Patient’s Address**
- **City**
- **State**
- **Zip**
- **Patient Medicaid ID #**
- **Patient Medicare ID #**
- **Date of Birth (MM-DD-YYYY)**

### TYPE BILL

- **Statement Covers Period**
  - **From (MM-DD-YYYY)**
  - **Through (MM-DD-YYYY)**
- **Primary Diagnosis Code (s)**
- **List All Other Diagnosis Codes**

### DISCHARGE/REVOCATION REASON(S):

### PROVIDER INFORMATION

- **Hospice Provider Name**
- **Hospice Address**
- **City**
- **State**
- **Zip**
- **Hospice Provider #**
- **Hospice Provider Phone # (incl. area code & Fax)**
- **Name of Nursing Facility or Intermediate Care Facility (ICF-DD)**
- **Attending Physician Printed Name**
- **Attending Physician Provider #s**
- **Hospice Relationship Status**

### SIGNATURES

- **Hospice Provider Representative’s Signature**
- **Hospice Representative’s Printed Name**
- **Date (MM-DD-YYYY)**

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Reissued March 2012  Prior Issues Obsolete

**This form cannot be altered**  BHSF Form Hospice-NOE