Medicaid Hospice Care Notification Form

To be used for Election, Revocation, Change in Designated Hospice, or Death Notification

A copy of the Terminal Certification and the Plan of Care must be submitted with this form

Please Check Appropriate Box

[ ] Initial Election of Medicaid Hospice Date of Election: _____
[ ] Recipient also has Medicare [ ] If recipient has Medicare, elected the hospice benefit under Medicare
[ ] Recipient has another insurance List Insurance: _____

[ ] Change in Level of Care Notification (fill in box below) [ ] Change in Provider Notification (fill in box below)

[ ] Revocation or Death Notification (fill in box below)

Provider Information

Designated Hospice Provider: _____ Medicaid Provider #: _____
Address: _____
Phone #: _____ Fax #: _____
Attending Physician: _____
Name of Nursing Facility in which Recipient Resides (if applicable): _____

Recipient Information

Name of Recipient: _____ D.O.B.: _____
Address: _____
Diagnosis: _____ Medicaid ID #: _____
Prognosis: _____
Name of Agent or Legal Guardian (if applicable): _____

Hospice Benefit Election Period (circle one and start and end dates are REQUIRED)

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
Start Date _____ End Date _____

Change in Level of Care Notification

Effective Date: _____ End Date: _____ **submit plan of care documentation**

Change in Hospice Provider Notification

Effective Date: _____ New Hospice Provider: _____
Phone #: _____ Fax #: _____ Provider #: _____

Revocation Or Death Notification

Date of Revocation: _____ Date of Death: _____

Please forward this information to the Office of Medicaid Services via Fax# (603) 271-8194 or via US mail to: 129 Pleasant Street, Brown Building, Concord, NH 03301.

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