Medicaid Hospice Election and Physician's Certification

I, _____ _____ **elect to receive the Medicaid Hospice**
Patient's Name & Phone Number **Medicaid Number**

Benefit from _____ _____ _____ **to be effective** _____
Hospice Name **Provider No.** **Provider Phone No.** **Date**

Admitting Diagnosis Code(s) _____

PATIENT ACKNOWLEDGEMENT

I understand and acknowledge:

- **that the Medicaid Hospice Benefit consists of the following certification periods, and that each period must be approved by my attending physician and Hospice Medical Director at the beginning of the benefit period.**

1st Benefit Period - 90 Days
2nd Benefit Period - 90 Days
Subsequent Benefit Periods - 60 Days each

- **that if I reach a point of stability, and am no longer considered terminally ill, that the Hospice will be unable to recertify me, and I will return to the traditional Medicaid benefit.**
- **that by electing the Medicaid Hospice Benefit, I waive all rights to Medicaid covered services that are also covered under the Medicare Program related to the treatment of the terminal illness or related condition for which Hospice Care is elected.**
- **that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit simultaneously with the Medicaid Benefit.**

Check applicable statement and provide requested information as indicated:

☐ **I am a Medicare recipient and have elected the Medicare Hospice Benefit.**
My Medicare number is _____

☐ **I am not a Medicare recipient. (If I become eligible for Medicare I must notify hospice)**

☐ **I am currently a long term care facility resident residing at** _____
_____
Nursing Facility Name and Address

By this election I acknowledge that I have been fully informed and understand the services and limitations of hospice care available from the above named hospice under the Medicaid Hospice Benefit.

_____ _____
Patient's Signature or Mark **Date Signed (Election Date)**

_____ _____
Patient Representative's Signature **Date Signed (Election Date)**

_____ _____
Relationship to Patient **Witness Signature/Date**

PHYSICIAN CERTIFICATION

I certify that the above named patient is terminally ill based upon clinical judgement regarding the normal course of the individual's illness. I understand that intentional certification of patients as terminally ill for chronic debilitating diagnoses with documentation that fails to support the terminal illness will result in referral to Medicaid's Provider SUR Unit and further actions as determined by review.

Benefit Period	**Date**	**Physician's Signature/Status (Attending, Hospice Medical Director, Hospice Team Physician, etc.)**
1	_____	_____
2	_____	_____
Subsequent	_____	_____

Verbal Order Documentation (Initial Certification Only)

_____ _____
Date Signature/Title

_____
Physician's Printed/Typed Name

Form 165 **Alabama Medicaid Agency**
Revised 05/01