MEDICAID HOSPICE ELECTION

State Form 48737 (R / 11-04) / OMPP 0005

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

Effective date of Hospice Care	
Medicaid Hospice effective date (*State use only*)	**Signature of Hospice Analyst**

A. RECIPIENT INFORMATION		Primary hospice diagnosis (*ICD-#*):
Name of recipient (*last, first, middle initial*)		Recipient's Medicaid number
Address or other location if not private home (*number and street, apt. number, city, state, ZIP code*)		
Recipient's Social Security number	Telephone number ( )	Date of birth (*month, day, year*)
Name of parent, legal guardian or representative		Sex of recipient: ☐ Male ☐ Female

B. PROVIDER'S INFORMATION		Date of physician's verbal approval of hospice care (*month, day, year*)
Name of Hospice Provider		Medicaid Hospice Provider number
Name of Attending Physician		Hospice telephone number
Attending Physician Medicaid Provider number	(*If applicable*) Name of Nursing Facility	Nursing Facility Medicaid Provider number

C. HOSPICE BENEFIT INFORMATION		
1st Period (90 days)	2nd Period (90 days)	Indefinate number of 60 day periods (*circle as appropriate*) 1st 60 days 2nd 60 days 3rd 60 days 4th 60 days

D. ELECTION STATEMENT

(a) **The Indiana Medicaid hospice benefit has been explained to me.** I have been given the opportunity to discuss the services, benefits, requirements and limitation of this program and the terms of the election statement;

(b) **I understand** that by signing this election statement I waive all rights to regular Medicaid services except for payment to my attending physician and prior authorized treatment for services unrelated to my terminal illness, medical transportation unrelated to the terminal illness, dental services and Medicaid pharmacy services for prescriptions not covered under hospice;

(c) **I understand** that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible. The benefit will be provided in three benefit periods of an initial 90 days, a subsequent 90 days, and an unlimited period consisting of successive 60 day periods. I may qualify for each of these periods after review by the Indiana Office of Medicaid Policy and Planning and its contractor;

(d) **I understand** that I may revoke the hospice benefit at any time by completing a **Hospice Revocation Form**, specifying the date when the revocation is to be effective and submitting the form to the hospice provider at the time of revocation. I also understand that if I choose to revoke services for a benefit period, I am not entitled to coverage of the remaining days of that benefit period. At the time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided that I continue to be Medicaid eligible;

(e) **I understand** that I may change the designated hospice provider one time per election period without affecting the provision of my hospice benefit and that to do so my hospice provider is required to fill out a **Change of Hospice Provider Form**;

(f) **I understand** that if I am a Medicare recipient, I must elect to use the Medicare hospice benefit.

E. SIGNATURES	
Signature of recipient (*or recipient representative*)	Date (*month, day, year*)

(*See reverse side for the Election Statement in large print*)

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