MISSISSIPPI DIVISION OF MEDICAID

Physician Certification/Recertification of Terminal Illness

Certification of the terminal illness must be completed by the Hospice Medical Director or the Hospice Interdisciplinary Group (IDG) Physician, and the Attending Physician, if any, within two (2) calendar days of the initiation of hospice care. Recertification of the terminal illness must be completed by the Hospice Medical Director or IDG physician no later than two (2) calendar days after the beginning of that period. Certifications/Recertifications cannot be complete more than fifteen (15) calendar days prior to the start of each benefit period. A nurse practitioner is not allowed to certify or recertify the terminal illness.

Beneficiary Information

Name:	Date of Birth:
Current Address:	Medicaid ID Number:
	Medicare Number:
Contact Number:	Social Security Number:
Name of Guardian/Legal Representative: Relationship:	
Name of Beneficiary's Attending Physician, if any:	Name of Nursing Facility, if applicable:
Attending Physician Contact Number:	Nursing Facility Medicaid Provider Number:

Provider Information

Name of Hospice Provider:	Hospice Medicaid Provider Number:
Address:	Hospice Contact Number:
Name of Hospice Medical Director:	Name of Hospice Interdisciplinary Group (IDG) Physician:

Election Period

□ 1st 90-day certification from ____/____/_____ to ____/____/_____

□ 2nd 90-day recertification from ____/____/_____ to ____/____/_____

□ 3rd 60-day recertification from ____/____/_____ to ____/____/_____

□ 4th 60-day recertification from ____/____/_____ to ____/____/_____

If in another Election Period, please indicate:

□ ___ 60-day recertification from ____/____/_____ to ____/____/_____

Face-to-Face encounter prior to 3rd and subsequent election periods

(a face-to-face encounter must occur prior to, but no more than thirty (30) days prior to, the 3rd election period recertification and every election period recertification thereafter)

Face-to-Face Encounter performed on _____ by:
Date/Time

□ **Certifying physician.**

□ **Practitioner other than the certifying physician:**

I attest that I performed a face-to-face encounter with the beneficiary and that the clinical findings of the face-to-face encounter were provide to the certifying physician for use in determining continued clinical eligibility for hospice care.

Printed Name/title_____

Signature_____Date _____

Physician Certification/Recertifications Statement of Terminal Illness

Terminal illness diagnosis(es) and related conditions ICD-10 codes:

_____

Clinical explanation supporting terminal illness with six (6) month or less prognosis including guidelines from local coverage determinations, as applicable, for each certification/recertification period: Is narrative continued on attachment? □ Yes □ No

_____

_____

_____

_____

I confirm that I composed this narrative based on my review of the beneficiary's medical record and/or examination and certify that the above named beneficiary is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the beneficiary's illness. I understand that intentional certification of beneficiaries as terminally ill for chronic debilitating diagnoses with documentation that fails to support the terminal illness will result in referral to the Medicaid Fraud Control Unit.

Physician (printed name)_____Signature_____Date/Time_____
Please indicate: □ Hospice Medical Director □ Hospice IDG Physician

Attending Physician (printed name)_____ Signature_____Date/Time_____
(Attending physician signature required for the initial certification when the beneficiary has an attending physician)

Exclusion Statement
I certify that the beneficiary identified above does not have an attending physician separate from the hospice medical director or IDG physician.

Physician signature _____Date_____

Verbal Verification (within two (2) days of election date)

I attest on the date signed that a verbal verification was obtained from Dr. _____certifying that the beneficiary's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course.

Name (print)_____Signature_____Date/Time_____