Hospice Discharge/Hospice Revocation Form

MISSISSIPPI DIVISION OF MEDICAID

Beneficiary Information	
Name:	Date of Birth:
Address:	Medicaid ID Number:
	Medicare Number:
Contact Number:	Social Security Number:
Name of Guardian/Legal Representative: Relationship:	
Name of Beneficiary's Attending Physician:	Attending Physician Contact Number:
Hospice Provider Information	
Name:	Medicaid Provider Number:
Address:	NPI Number:
	Contact Number:

Reason: Complete Box 1 or Box 2

Box 1

Beneficiary Revocation Statement:

a) The Medicaid Hospice Program has been explained to me. I have been given the opportunity to discuss the services, benefits requirements and limitations of this program and the terms of the revocation of these services,

b) I understand that by signing this revocation statement I will, if eligible, resume Medicaid coverage of benefits waived when the hospice care was elected,

c) I will forfeit all hospice coverage for days remaining in this benefit period,

d) I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

_____ _____

Signature of Beneficiary or Guardian/Legal Representative *Date*

_____ _____

Signature of Hospice Staff *Date*

Box 2

Hospice Discharge

The above named beneficiary was admitted to hospice on ___/___/____ and discharged on __/__ /____ for the following reason:

Beneficiary deceased on _____/_____/_____.

The beneficiary is no longer eligible for Medicaid.

Beneficiary's condition has improved and is no longer certified as terminally ill.

Beneficiary moved out of state/service area.

Safety of beneficiary or hospice staff is compromised. (Explanation must appear below)

Beneficiary is non-compliant. (Explanation must appear below and documentation efforts to counsel the recipient must be attached).

The beneficiary has transferred to another hospice provider. (Complete the transfer form)

Explanation:_____

_____