

Idaho Dept. of Health and Welfare, Medical Care Unit, Medicaid

HOSPICE NOTIFICATION FORM

Submit this form within 15 working days of election or any change in patient status.

Date of Fax:

Medicaid Participant Information

Last Name: First Name: Initial:
MID#: County of Residence: Date of Birth:
Residence: [] Home [] RALF [] Certified Home [] SNF** [] ICF/ID** [] Hospice House
Insurance Carriers (Select All That Apply): [] Medicaid [] Medicare [] 3rd Party:
Primary ICD Code: Primary Hospice Diagnosis:

Medicaid Provider Information

Provider Name: Phone:
NPI: City: State:
Primary Contact: Email:

Medical Review to Determine Hospice Eligibility

Directions: Medical Review occurs for ALL Medicaid participants receiving hospice care. Required documents must be faxed with request. Hospice provider will receive weekly e-mail log documenting Election and Recertification dates.

[] ELECTION (eight mos. OR end of care date) from: ___/___/___ to: ___/___/___

Required documents:

- The hospice election form signed by the participant or legal representative.
A physician's History and Physical, or Discharge Summary, within six months, or the hospice nursing assessment at Election.
The hospice agency's completed Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director.
A certification stating that the individual's medical prognosis for life expectancy is six months or less and signed by the Hospice Medical Director and the attending physician, if the participant has one.

[] RECERTIFICATION (eight mos. OR end of care date) from: ___/___/___ to: ___/___/___

Required documents:

- The hospice agency's completed Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director.
A certification stating that the individual's medical prognosis for life expectancy is six months or less and signed by the Hospice Medical Director.
Documentation of compliance with CMS eligibility standards for participant's specific hospice diagnosis (i.e. Local Coverage Determination (LCD) or Criteria Worksheet).

Authorization for Room and Board: Revenue Code 0658

Directions: All skilled facility Room & Board payments must pass through hospice if Medicaid has approved Long Term Care. These AUTHs are created when election or recertification documents, if appropriate, are faxed. Complete this section after election is approved, if a participant moves to a facility, discharges from a facility, or moves to a different facility.

ROOM & BOARD AUTHORIZATION REQUEST for SNF or ICF/ID ONLY.

Skilled Nursing Facility or Intermediate Care Facility Name: _____

_____/_____/_____ to ____/____/_____ (eight mos. OR until last Room & Board date)

Authorization for Routine Home Care: Revenue Code 0651, Days 1-60

Directions: Participants with Third Party Insurance and/or Medicaid primary require a prior authorization to claim a higher rate for Revenue Code 0651 during the first 60 days of Hospice care. Not applicable to Medicare primary beneficiaries, general inpatient Revenue Code 0656, or Respite Revenue Code 0655. This AUTH number must be entered on the claim. Day 61 and beyond does not require a prior authorization. If the participant has passed away, revoked, or discharged enter the end of care date accordingly.

Election: Up to Eight Month Authorization

Day 1 to Day 60 (Higher Rate) from: ____/____/_____ to: ____/____/_____

No AUTH is required to bill for GIP or Respite stays, but Revenue Code 0651 AUTHs will be modified accordingly.

General Inpatient Stay Revenue Code 0656 from: ____/____/_____ to: ____/____/_____

Respite Stay Revenue Code 0655 from: ____/____/_____ to: ____/____/_____

Authorization for Service Intensity Add-On: Revenue Code 0651

Directions: Participants with Third Party Insurance and/or Medicaid primary may be authorized for RN or LCSW provided the last seven days of life. Not applicable to Medicare primary beneficiaries. Enter the number of **15 minute increments**, not to exceed a total of 16 per day. Supporting documentation is not required unless requested.

| Day | Dates | Higher or Reduced Rate? | LCSW | RN |
|--------------|-------|--|------|----|
| Day 1 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Day 2 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Day 3 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Day 4 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Day 5 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Day 6 | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Expired | | <input type="checkbox"/> Higher <input type="checkbox"/> Reduced | | |
| Total | | | | |

End of Care Notification

TERMINATION* date of current episode of hospice care: ____/____/_____

Due to: Deceased Revoked Discharged *Applicable AUTH will be end dated.

If participant chose another hospice, please, note the name: _____

Notes