MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

NAME: LAST FIRST		SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:		MEDICARE NUMBER:

PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

DISCHARGE STATEMENT:

Hospice benefits for the above named recipient, enrolled with this agency since _____ terminated _____for the following reason: (check all that apply):

_____ Recipient is deceased. Date of death is _____/_____/_____.

_____ Prognosis is now more than six (6) months.

_____ Recipient moved out of state / service area.

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

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

EXPLANATION:

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed above recipient has the right to a fair hearing regarding the decision. Procedures regarding that appeal are found on the reverse side of this page. The signature below indicates that the recipient was given this statement for his/her records/use.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:

DHHS FORM 154 (10/95) (REVISED 06/08) This form must be forward to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective of the discharge.