VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

DMAS 420 Request for Hospice Services

NAME: _____ ADDRESS:	DATE OF BIRTH: _____/_____/_____
MEDICAID BENEFIT PROGRAM: FFS ☐ CCC Plus Program ☐ OTHER INSURANCE: _____ POLICY NO. _____	MEDICAID #: _ _ _ _ _ _ _ _ _ _ _ _ (12 digits) MEDICARE #_____

SECTION I: ELECTION OF HOSPICE SERVICES

I, _____, elect to participate in the Medicaid Hospice Services.

The hospice that I have chosen is _____.

I am aware of the prognosis of my illness and I understand that treatment is palliative rather than curative. I consent to the management of the symptoms of my disease as prescribed by my Attending Physician and/or the Hospice Medical Director. My family and I will help to develop and will participate in a plan of care based on our needs.

I may receive benefits that include home nursing visits, counseling, medical social work services, drugs and biologicals, and medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, inpatient care for acute symptoms, medical procedures ordered by my physicians and hospice, and continuous nursing care in the home during acute medical crises. I may request volunteer services, when available and appropriate. I realize that my family and I have the opportunity for limited respite in an approved inpatient facility.

In accepting these services, which are more comprehensive than regular Medicaid Services, I waive my right to regular Medicaid services that are duplicative of services required to be provided by the Hospice except for payment to my Attending Physician or treatment for medical conditions unrelated to my terminal illness. I understand that I can revoke these services at any time and return to regular Medicaid services. I understand that Hospice consists of two ninety-day periods and subsequent sixty-day periods extending until I am no longer in Hospice. I may be responsible for hospice charges if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time. I also understand that if I choose to do so, I am still eligible to receive the remaining benefit period(s). I am aware, that if I choose to revoke Hospice Services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period, I may change the designations of the particular hospice from which hospice care is provided by filing a statement with the hospice from which care has been provided and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke Hospice services, hospice coverage will continue.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Services.

Check one:

_____ I am a Medicare recipient and have elected the Medicare Hospice Services.
My Medicare eligibility for hospice benefits begins _____ (date).

_____ I am not a Medicare recipient.

_____ _____

Witness' Signature/Date Hospice Recipient Signature/Date

_____

Hospice Recipient's Authorized Representative Signature/Date (If applicable)

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REQUEST FOR HOSPICE SERVICES-CONTINUED

SECTION II: HOSPICE PROVIDER INFORMATION

Hospice Provider Name:_____	Contact Person: _____
Hospice Provider NPI: _____	Phone Number: _____
Enrolled in: ☐ CCC Plus ☐ FFS	FAX Number: _____
Plan Name:_____	Date Submitted: _____

SECTION III: PHYSICIAN CERTIFICATION

Recipient's Name: _____

I certify that, in my best judgment, the reasonable, medical predictable life expectancy for this individual is 6 months or less. Based on this medical prognosis I am requesting Medicaid Hospice Benefits for this individual beginning _____ (date). I understand that unless the individual revokes Hospice Services, hospice services will continue as long as the individual remains eligible for Medicaid.

_____ _____

Attending Physician (typed or printed) Hospice Medical Director (typed or printed)

__ __/ __ __ / __ __ __ __/ __ __ / __ __

_____ _____

Attending Physician (Signature/Date) Hospice Medical Director (Signature/Date)

SECTION IV: NOTICE OF RE-ELECTION OF HOSPICE BENEFIT

I certify that, in my best judgment, the reasonable, medical predictable life expectancy for this individual is 6 months or less. Based on this medical prognosis, I am requesting Medicaid hospice services for this individual beginning _____ (date). I understand that unless the individual revokes hospice services, hospice services will continue as long as the individual remains eligible for Medicaid.

Benefit Period: From_____to_____

Hospice Medical Director's (Typed or Printed Name) _____

*Hospice Medical Director's Signature/Date*_____