

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

A. RECIPIENT INFORMATION			Primary hospice diagnosis (ICD-#):			
Name of recipient (last, first, middle initial)			Recipient's Medicaid number			
Recipient's Social Security number						
B. PROVIDER INFORMATION						
Name of hospice provider			Hospice Medicaid provider number			
Please check the appropriate benefit period below:						
1st hospice benefit period			-			
2n hospice benefit period						
3rd hospice benefit period						
Should <u>additional</u> hospice care be required after the first 60 days of the Third Benefit Period, please complete this page again and check the appropriate box below.						
THIRD BENEFIT PERIOD (SUBSEQUENT 60 DAY PERIODS)						
2nd 60 days	3rd 60 days	4th 60 days		5th 60 days		6th 60 days
Please specify the number of any subsequent benefit period						
C. Having reviewed this patient's care and the course of his / her illness, I certify that this patient's medically predictable life expectancy is (6) months or less, given that the illness runs its normal course, as evidenced by the following clinical indications.						
Signature of Attending Physician (Required first hospice benefit period)					Certification da	ate (<i>month, day, year</i>)
Signature of Medical Director or	Hospice Physician				Certification da	ate (<i>month, day, year</i>)