# MEDICAID HOSPICE DISCHARGE

State Form 48734 (R / 12-02) / OMPP 0008

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. HOSPICE PROVIDER INFORMATION** | |
|---|---|
| Name of Hospice Provider | Hospice Provider number |

**C. DISCHARGE STATEMENT**

Hospice benefits for the above named recipient, enrolled with the above named provider since _____ / _____ / _____ have terminated on _____ / _____ /_____ for the following reasons:

- ☐ Recipient is deceased. Date of death was _____ / _____ / _____ .
- ☐ Prognosis is now greater than six months.
- ☐ Safety of recipient or hospice staff is compromised (*explain below and attach revelent documentaion*).
- ☐ Recipient moved out of service area.
- ☐ Other (*explain below*)

| Signature of Medical Director or Patient Care Coordinator | Date |
|---|---|
| | |