HOSPICE AUTHORIZATION NOTICE FOR DUALLY-ELIGIBLE MEDICARE / MEDICAID NURSING FACILITY RESIDENTS

State Form 51098 (3-03) / OMPP 0014

This completed form is CONFIDENTIAL according to 405 IAC 1-16, 5-2-10.1, 5-1-10.2, 5-5-1, and 5-34.

The purpose of this form is to enroll nursing facility residents who elect the Medicare hospice benefit in the Medicaid hospice benefit to ensure payment of room and board services as required under 405 IAC 1-16-4. The hospice provider understands that the only time this enrollment form must be completed again is if the individual reelects hospice care following a hospice discharge or hospice revocation. **Through the primary hospice nurse's signature on the bottom of this form**, the hospice provider certifies that all medical documentation has been completed according to the Medicare Conditions of Participation for Hospice Care and Medicaid program guidelines and that all required Medicaid forms have been included in the patient's medical chart in the hospice agency and contracted nursing facility.

The hospice provider must still complete the Medicaid hospice election form, Medicaid physician certification form and Medicaid hospice plan of care for the Medicaid-only nursing facility resident as required for each hospice benefit period.

Date of the original Medicare hospice election: (*Attach signed copy of Medicare election statement*)	Previous hospice enrollee? ☐ Yes ☐ No
Date of Medicare hospice re-election (*This section is for the date that the member re-elects hospice following a preceding hospice revocation or hospice discharge.*)	
Current hospice benefit period ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	

A. RECIPIENT INFORMATION

Primary hospice diagnosis (ICD#)		
Name of recipient (*last, first, middle initial*)	Recipient's Medicaid number	
Address or other location if not private home (*number and street, apt. number, city, state, ZIP code*)		
Recipient's Social Security number	Telephone number ( )	Date of birth (*month, day, year*)
Name of parent, guardian or representative		Sex of recipient ☐ Male ☐ Female

B. PROVIDER'S INFORMATION

Date of physician's verbal approval of hospice care (*month, day, year*)		
Name of hospice provider		Medicaid hospice provider number
Name of attending physician		Hospice telephone number
Attending physician Medicaid provider number	Name of nursing facility (*if applicable*)	Nursing facility Medicaid provider number

Signature of Primary Hospice Nurse (RN) and title	Date (*month, day, year*)

This form must be completed in its entirety to be processed by the Medicaid prior authorization contractor to ensure hospice authorization. Hospice authorization is required for the dates of service that the hospice bills for room and board services.