Georgia Families
Choices for a Healthy Life

MANAGED CARE HOSPICE ELECTION/REVOCATION FORM

This form is used to inform and enable Care Management Organizations (CMOs) to authorize Hospice services provided to eligible Georgia Families members. After completing this form, fax to the appropriate Care Management Organization (CMO). **Please note: Members will remain in their CMO until their category of aid is changed to Hospice**.

CHECK ONE:

☐ Amerigroup Community Care:
Phone: 800-454-3730
Fax: *770-395-9282*
ATTN: Case Management
http://www.amerigroupcorp.com

☐ Peach State Health Plan:
Phone: 800-704-1483
Fax: 866-532-8835
ATTN: Case Management
http://www.pshpgeorgia.com

☐ Wellcare:
Phone: *866-231-1821*
Fax: *877-431-8860*
ATTN: Case Management
http://georgia.wellcare.com

SECTION I- FACILITY AND/OR MD TO COMPLETE FOR ALL HOSPICE MEMBERS

Member Information

Member Name (Last, First, MI) _____

Medicaid Number (MHN): _____ Date of Birth:(MM/DD/YYYY) _____

CMO ID # (if applicable): _____

Additional Information: _____

Hospice Information

Facility Name: _____

Phone Number: _____ Fax Number _____

Facility Address: _____ City/State: _____ Zip Code: _____

Attending Physician: _____ Medicaid Provider Number: _____

Clinical Information and Diagnosis (ICD-9 Code): _____

SECTION II- MEMBER STATEMENT
TO BE COMPLETED BY MEMBER

☐ **ELECTION STATEMENT:**

- The Georgia Medicaid Hospice Service has been explained to me. I have been given the opportunity to discuss services, benefits, requirements and limitations of this program and the terms of the election statement.
- I understand that by signing the election statement I am waiving all rights to regular Medicaid services except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.

- I can choose to discontinue hospice care at any time. To discontinue care, I must complete a revocation statement.
- I understand that I am entitled to change the designated hospice provider one time during a benefit period.
- I understand that I am entitled to Medicaid sponsored Hospice as long as I am Medicaid eligible. The services are provided in benefit periods of initial ninety (90) day period, subsequent ninety (90) day period, and unlimited subsequent sixty day periods.

Print Name (Member/Representative): _____ Date: _____

Signature (Member/Representative): _____ Date: _____

Hospice Representative Signature: _____ Date: _____

SECTION III- REVOCATION STATEMENT

An individual or representative may revoke the election of hospice care at any time during an election period. To revoke the election of hospice care, the individual or representative must file a revocation statement with the hospice.

☐ **REVOCATION STATEMENT:**

- I desire to voluntarily revoke the election of hospice care.
- The Georgia Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the revocation of these services.
- I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.
- I understand I will forfeit all hospice coverage days remaining in this benefit period.
- I understand that I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

I therefore revoke the hospice benefit because: _____

_____

_____

Effective Date: _____

Print Name (Member/Representative): _____ Date: _____

Signature (Member/Representative): _____ Date: _____

Hospice Representative Signature: _____ Date: _____

SECTION IV- CMO USE ONLY

Date Received: _____ Approved: ☐ YES ☐ NO Date Effective: _____

Notification of Member Date: _____ Notification of Provider Date: _____

Reason for Denial: _____

_____

_____