Wellstar HEALTH SYSTEM

Medicaid Hospice Election

Member Information

Name | Medicaid Number

Address

Social Security Number | Date of birth

Hospice Information

Hospice Name | Provider Number

Address

Phone Number

Effective Date for Hospice Care

Primary Diagnosis | ICD Code | Date of Onset

Attending Physician Information

Attending Physician | Medicaid/NPI Number

Date Last Seen

Election Statement

- I understand that my physician has certified me as being terminally ill with a medical prognosis of six (6) months or less, if the disease runs its normal course.
- 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 this program and the terms of the election statement.
- (Adults over the age of 21 only) 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 understand that I will be entitled to Medicaid sponsored hospice services if I am Medicaid eligible and physician certified as required for each benefit period. These services are provided in benefit periods for an initial ninety (90) day period, a subsequent ninety (90) day period and for each subsequent sixty (60) day period.
- I understand that I may revoke the hospice benefit at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date; however, 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. At the same time, I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.
- I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice providers, I must dis-enroll with the hospice from which care has been received and elect a new hospice provider.
- I understand that if I am a Medicare beneficiary, I must elect to use the Medicare Hospice Benefit.
- I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

My choice for my attending physician: _____

Member/Representative Signature Date

Hospice Representative Date

Nursing Facility (if applicable)

I understand that this individual's election of the hospice benefit and waiver of Medicaid reimbursement for nursing facility services for the duration of election under the hospice program. Medicaid reimburses the hospice provider for nursing facility room and board when the individual resides in the nursing facility and the hospice reimburses the nursing facility for room and board charges.

Nursing Facility Representative Signature Date