Election Notice Form

MISSISSIPPI DIVISION OF MEDICAID

Hospice providers must notify the Division of Medicaid's UM/QIO within five (5) calendar days of a beneficiary's admission to hospice.

Beneficiary Information (To be filled out by Hospice Provider)	
Name:	Date of Birth:
Current Address:	Medicaid ID Number:
Contact Number:	Social Security Number:
Guardian/Legal Representative:	Relationship to Beneficiary:
Beneficiary's Attending Physician, if any:	Nursing Facility, if applicable:
Attending Physician Contact Number:	Nursing Facility Medicaid Provider Number:
Provider Information	
Hospice Provider:	Hospice Medicaid Provider Number:
Address:	Hospice Contact Number:
Hospice Medical Director:	County where services will be provided:
Hospice Interdisciplinary Group (IDG) Physician:	
Election Date	
Election Date:	

Election Statement (To be read and signed by Medicaid Hospice Beneficiary)

- I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed towards a cure of my terminal illness. The focus of hospice care is to provide comfort and support to both myself and my family and/or caregivers.
- I understand that if I am a Medicare recipient, I must elect the Medicare hospice benefit.
- I understand that by signing this election statement I waive all rights to regular Medicaid for the treatment of my terminal illness and related conditions except for payment to my attending physician and for services unrelated to my terminal illness.
- If I am under the age of 21, I may receive hospice benefits including curative treatment without foregoing any other service to which a child is entitled under the Medicaid program. I understand that upon turning twenty-one (21), I will no longer be eligible to receive concurrent hospice care and curative treatment services for my terminal illness.
- I understand that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible and certified as terminally ill. The benefit periods consist of an initial 90 day, a subsequent 90 day, and subsequent 60 day periods.
- I understand that if I reach a point of stability, and am no longer considered terminally ill, I will not be recertified as terminally ill and my benefits will revert to regular Medicaid benefits, if I am still eligible for Medicaid.
- I understand that the effective date of the election period cannot be earlier than the date of the election statement.
- The hospice provider I have chosen will receive payment for the care of my terminal illness and related conditions as well as my attending physician. I may change the designated hospice care service provider one time per election period without affecting the provision of my hospice benefit by completing a hospice transfer statement.
- I may revoke the hospice care benefit at any time during an election period by signing a statement indicating that I'm revoking the hospice election with the date the revocation is to be effective and submitting the statement to the hospice prior to the effective date of the revocation. I may at any time elect to receive hospice coverage for any other hospice election period as long as I am eligible.
- I have the right to choose my attending physician to oversee my care. My attending physician, if any, will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions. Do you have an attending physician?

☐ No, I do not have an attending physician.

☐ Yes, my attending physician is:

_____
Physician's Name

_____ _____
Physician's Office Address *Physician's Individual NPI*

By signing below, I acknowledge the above Election Statement and choose to elect the Medicaid hospice benefit and choose to receive hospice care services from the listed Hospice Provider beginning on the election date listed above:

_____ _____
Signature of Beneficiary or Guardian/Legal Representative *Date*