

## MEDICAID HOSPICE ELECTION FORM

EFFECTIVE DATE: \*\*INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS\*\*

### RECIPIENT INFORMATION:

NAME: LAST		FIRST	MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET		SOCIAL SECURITY NUMBER:	
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:
HOME PHONE NUMBER:	BIRTH DATE:	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS::	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::		MEDICAID PROVIDER NUMBER OF NURSING FACILITY::	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:		SEX: MALE / FEMALE	

### HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP ___ _ _
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:
ATTENDING PHYSICIAN'S NAME:	PHYSICIAN'S MEDICAID PROVIDER NUMBER:

### HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

FIRST 90 DAYS                     
  SECOND 90 DAYS                     
 (    ) PERIOD OF 60 DAYS

### ELECTION STATEMENT

- The South Carolina Medicaid Hospice Benefit 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.
- I understand that by signing the election statement, I am waiving all rights to regular Medicaid services except for payment to my attending physicians, 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 as long as I am Medicaid eligible. These services are provided in benefits periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.
- I understand that I may revoke the hospice benefits 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 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 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 programs, I must disenroll with the hospice from which care has been received and elect a new hospice provider.
- I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.
- I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

### SIGNATURES:

RECIPIENT OF RECIPIENT REPRESENTATIVE SIGNATURE / DATE:	WITNESS SIGNATURE / DATE:
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DHHS FORM 149 Revised 06/08 Previous versions are obsolete.

\*\* This form must be forwarded to the SCDHHS Medicaid Hospice Programs within ten (10) days of election of benefits. Failure to submit this form within that time frame will result in a change of the election date to the date this form is received by SCDHHS.