Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries

Hospice providers must notify the Division of Medicaid's UM/QIO within five (5) calendar days of the hospice election and discharge date for dual eligible beneficiaries.

MISSISSIPPI DIVISION OF MEDICAID

Beneficiary Information	
Name:	Date of Birth:
Address:	Medicaid ID Number:
	Medicare Number:
Contact Number:	Social Security Number:
Guardian/Legal Representative:	Relationship to Beneficiary:
Beneficiary's Attending Physician:	Attending Physician Contact Number:
Hospice Provider Information	
Name:	Medicaid Provider Number:
Address:	NPI Number:
	Contact Number:
County in which services will be provided:	
Nursing Facility, if applicable:	Nursing Facility Medicaid Number:

Choose One of the Following:

Hospice Election ☐

☐ The beneficiary has chosen to elect the Hospice

Election date: _____

_____ _____

Signature of Beneficiary or Guardian/Legal Representative *Date*

Hospice Discharge ☐

The beneficiary was discharged on _____/_____/_____ for the following reason:

☐ Beneficiary deceased on _____ / _____/ _____.

☐ Beneficiary is no longer eligible for Medicaid.

☐ Beneficiary's condition has improved and is no longer certified as terminally ill.

☐ Beneficiary moved out of state/service area.

☐ Beneficiary has transferred to another hospice provider. (Complete the transfer form)

☐ Beneficiary non-compliant. (Explanation must appear below and documentation efforts to counsel the recipient must be attached).

☐ Safety of beneficiary or hospice staff is compromised. (Explanation must appear below, details may be attached)

Explanation:_____

_____ _____

Signature of Hospice Staff *Date*