Mississippi Medicaid Hospice

Disenrollment Form

To be completed upon disenrollment.

Instruction for Completing the
Mississippi Medicaid Hospice Disenrollment Form:

1. Enter the Beneficiary's name exactly as it appears on his/her Medicaid ID Card.
2. Enter the Beneficiary's Medicaid ID #
3. Enter the Hospice provider name.
4. Enter the Hospice Provider's Medicaid ID#
5. Enter the effective date of disenrollment.
6. Enter the county where services were rendered.
7. Enter the Beneficiary's Social Security Number.
8. Indicate the reason for disenrollment. If 6 (other), please explain.
9. Allow the beneficiary/legal representative time to read the form. Have the beneficiary/legal representative sign and date the form.
10. Have the provider's representative sign and date the form.

Mississippi Medicaid Hospice

Disenrollment Form

To be completed upon **disenrollment**. Please print in ink or type. See instructions.
Mail a copy to:
ACS
Attention: File Maintenance
P. O. Box 23076
Jackson, MS 39225

Beneficiary Information

Name (Last, First and Middle Initial)	
1.)	
Beneficiary's Medicaid ID#	***Hospice Provider's Name***
2.)	**3.)**
Hospice Medicaid's Provider ID#	***Effective Date of Disenrollment***
4.)	**5.)**
County where services were rendered	***Social Security Number***
6.)	**7.)**

8.) Reason for Disenrollment:

1	☐ Voluntary disenrollment	**4**	☐ Seeking treatment other than palliative in nature
2	☐ No longer meets hospice requirements	**5**	☐ Death
3	☐ Hospitalization unrelated to terminal illness	**6**	☐ Other_____

THIS DISENROLLMENT FORM MUST BE COMPLETED, SIGNED AND DATED, FILED IN PATIENT'S MEDICAL RECORD, AND A COPY TRANSMITTED TO DOM'S FISCAL AGENT WITHIN 48 HOURS OF THE DISENROLLMENT, OR THE HOSPICE WILL BE RESPONSIBLE FOR ANY OR ALL CHARGES INCURRED BY THE BENEFICIARY.

The beneficiary forfeits coverage for any remaining days in that election period. The beneficiary may not designate an effective date earlier than the date that the revocation was made.

Upon revoking the election of Medicaid coverage of hospice care for this particular election, I understand that I resume Medicaid coverage of benefits waived when hospice care was elected, providing I remain eligible for Medicaid coverage. I also understand that I can re-elect hospice coverage for any other hospice benefits for which I am eligible.

Signature of Beneficiary/Legal Representative	***Date***
Signature of Hospice Representative	***Date***