Mississippi Medicaid Hospice Form

Instructions for Completing the Mississippi Medicaid Hospice Form:

(1) Complete the individual's name **exactly** as it appears on his/her Medicaid card.

(2) Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.

(3) Complete the individual's Social Security number **exactly** as it appears on his/her Medicaid card.

(4) Complete the individual's Medicare number **exactly** as it appears on his/her Medicare card.

(5) Complete the individual's date of birth.

(6) Complete the individual's area code and phone number.

(7) Complete the individual's street address.

(8) Complete the individual's city, state, and zip code.

(9) Complete the name of parent, legal guardian, or legal representative (if applicable).

(10) Complete by checking the appropriate box for the hospice benefit period and fill in requested effective date of segment.

(11) Complete the hospice's Medicaid provider name

(12) Complete the hospice's Medicaid provider number.

(13) Complete the name of the nursing facility where the beneficiary resides (if applicable).

(14) Complete the nursing facility's Medicaid provider number (if applicable).

(15) Complete the attending physician's name.

(16) Complete the county where actual services will be rendered.

(17) Complete the "group rate" code (refer to section 14.11 of the Hospice manual).

(18) Have the provider's representative sign the form.

(19) Have the provider's representative date the form.

Election Statement: Allow beneficiary/legal representative time to read closely. Have beneficiary/legal representative sign indicating Enrollment or Disenrollment in the hospice program. **The hospice provider's representative who is present must sign as the witness.**

Election Statement Form

The Mississippi Medicaid Hospice Care Services program has been explained to me. I have been given the opportunity to discuss the 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 Medicaid for the duration of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice) and;

2. Any Medicaid services that are related to the treatment of the condition, or a condition, for which hospice care was elected or that are equivalent to hospice care with the following exception: services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services).

I understand that I will be entitled to Medicaid hospice care coverage for the enrolled benefit segment as long as I am Medicaid eligible.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.

I understand that I may change the designated hospice provider 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.

Beneficiary Name	***Beneficiary Medicaid Number***
Address (Street Address, City, State and Zip Code)	

By signing this statement, I am electing the above named hospice to provide me with the services of the Medicaid hospice care program.

Beneficiary/Legal Representative's Signature	***Date***
Provider Signature (Must be present)	***Date***
Provider Name	***Provider Number***

Mississippi Medicaid Hospice

Enrollment Form

To be completed upon **enrollment**. 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.)	
Medicaid #	***Social Security #***
2.)	**3.)**
Medicare ID#	***Date of Birth***
4.)	**5.)**
Home Phone Number	***Street Address***
6.)	**7.)**
City, State and Zip Code:	
8.)	
Parent/Legal Guardian or Representative and Relationship:	
9.)	
10.) Hospice Benefit Period:	

☐ First 90 Day Segment ☐ Second 90 Day Segment

☐ 60 Day Period

Requested effective date of segment: _____

Provider Information

Hospice Provider Name	***Hospice Medicaid Provider #***
11.)	**12.)**
Nursing Facility Where Beneficiary Resides (if applicable)	
13.)	
Nursing Facility Medicaid Provider # (if applicable)	
14.)	
Attending Physician's Name:	
15.)	
County Where Services Will Be Rendered:	
16.)	
Group Rate Code	
17.)	
Provider Signature	***Date***
18.)	**19.)**