MAP-383
(Rev. 11/22)

HOSPICE
OTHER HOSPITALIZATION STATEMENT

CERTIFICATION OF HOSPITALIZATION

Name of Facility:	
Recipient Name:	DOB:
Member ID:	SSN:
Date of Admission:	Admission is **NOT** related to the terminal illness of this patient.
Reason for Admission:	
Admission Diagnosis:	ICD10 CM
Terminal Diagnosis:	ICD10 CM

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the KY Medicaid Program.

Medical Director Signature ______________________ Date ______________

HOSPICE AGENCY

Agency Name:	Telephone #:
Medicaid Provider #:	Fax #:

Provide and/or attach documentation verifying that hospitalization is NOT related to terminal illness.

First time hospitalization for a condition NOT related to the terminal illness? ☐Yes ☐No

Previous hospitalizations for conditions NOT related to terminal illness	
Date:	**Diagnosis:**
Date:	**Diagnosis:**
Date:	**Diagnosis:**
Date:	**Diagnosis:**

All sections above the approval line must be complete prior to review.

☐Approved by the Medicaid Program ☐Denied by the Medicaid Program

Medicaid/Reviewer Signature/Title ______________________ Date ______________