MAP-377
(Rev. 02/14)

PHYSICIAN'S CERTIFICATION FOR MEDICAID HOSPICE BENEFIT RECERTIFICATION STATEMENT FOR 60-DAY PERIOD

RECIPIENT INFORMATION

Recipient Name: _____

Medicaid ID Number: _____ or **Social Security Number:** _____

I certify that the above beneficiary is still considered terminally ill with a life expectancy of six (6) months or less, if the terminal illness runs its normal course. Additional 60 day periods are covered until revocation or termination for other reasons such as ineligibility, or death. Recertification is required for each 60 day benefit period, (after the end of the second benefit period.) The request for extension must be received by Department for Medicaid Services (DMS) five (5) days prior to the end of the 60 day benefit period.

Effective date of recertification: _____

Terminal diagnosis: _____

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for a continuation to hospice services.)

ATTESTATION

By signing, I confirm that I composed this narrative based on my review of the patient's medical record and/or my examination of the patient.

_____ _____

(Hospice Medical Director Signature) **(Date signed)**

SUBMIT FORM

Submit the completed form to the QIO.

CLEAR FORM