

## Termination of Medicaid Hospice Benefits

Hospice Benefits for \_\_\_\_\_ / \_\_\_\_\_  
(Patient Name) (Member #)  
are hereby terminated effective \_\_\_\_\_ for the following reason.  
(Month/Day/Year)

- Patient is deceased. Date of death is \_\_\_\_\_ .
- Patient is receiving hospice services from a hospice agency which does not participate with Kentucky Medicaid/(MCO).
- OTHER (Please clarify)

\_\_\_\_\_  
Hospice Agency Provider #

\_\_\_\_\_  
Agency Representative Date

Submit form by faxing to DMS at 502-564-0039 or email to DMS inbox at [dms.eligibility@ky.gov](mailto:dms.eligibility@ky.gov).