MAP-383
(Rev. 12/11)

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:		ICD9 CM
Terminal Diagnosis:		ICD9 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 _____

CLEAR FORM