MAP-377
(Rev. 11/20)

PHYSICIAN'S CERTIFICATION FOR MEDICAID HOSPICE BENEFIT RECERTIFICATION STATEMENT FOR 90/60 DAY PERIOD

RECIPIENT INFORMATION

Recipient Name: _____

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

Recertification is required for each additional benefit period. The request for extension must be uploaded into KLOCS. Recertification must be uploaded no later than 5 business days prior to the end of the benefit period.

One additional 90 day ☐ 60 day ☐

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.

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)**

Upload the completed form into KLOCS

CLEAR FORM