MAP-378
(Rev. 10/21)

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

Clear Form