Government of the District of Columbia
Department of Health Care Finance

Hospice Election and Physician Certification

SECTION A: BENEFICIARY			
Last Name:	First:	MI:	Medicaid Number:

I elect to receive Medicaid hospice benefit from:

SECTION B: HOSPICE		
Hospice Name:	Provider Number:	Provider Telephone:
Effective Date:	Admitting Diagnosis Code(s):	

SECTION C: BENEFICIARY ACKNOWLEDGEMENT

I understand and acknowledge: (☑ to indicate)

☐ that the Medicaid hospice benefit consists of the following certification periods, and that each period must be approved by attending physician and the hospice medical director at the beginning of the benefit period

- 1st benefit period – 90 days
- 2nd benefit period – 90 days
- Subsequent benefit periods – 60 days per

☐ that if I reach a point of stability, and am no longer considered terminally ill, the hospice will not recertify me for additional days
at the hospice facility and I will revert to the traditional Medicaid benefit

☐ that by electing the Medicaid hospice benefit, I waive all rights to covered Medicaid services that are also covered under the Medicare program related to the treatment of terminal illnesses or related condition for which hospice care is elected

☐ that if I am a Medicare recipient, I must elect to use the Medicare hospice benefit simultaneously with the Medicaid benefit

Check applicable statements and provide information as indicated

☐ I am a Medicare recipient and have elected the Medicare hospice benefit. My Medicare number is:_____

☐ I am not a Medicare recipient (If I become eligible for Medicare I must notify my hospice)

☐ I am currently a long term care facility resident at:

_____
Nursing Facility Name and Address:

By this election I acknowledge that I have I have been fully informed and understand the services and limitations of hospice care available from the hospice identified in Section B under the Medicaid hospice benefit:	Signature: Date Signed (Election Date):
Beneficiary Representative Signature:	Date Signed (Election Date):

SECTION D: PHYSICIAN CERTFICATION

I certify that the above-named patient is terminally ill based upon clinical judgment regarding the normal course of the beneficiary's illness. I understand that intentional certification of patients as terminally ill for chronic debilitating diagnoses with documentation that fails to support the terminal illness will result in referral to the Department of Health Care Finance Fraud Control Unit and further actions as determined by review.

Benefit Period Physician	Date of Benefit	Physician Status: ☐ Attending ☐ Medical Director ☐Hospice Team
1	_____	
2	_____	

Certification Statement:	
Physician Signature:	Date Physician Signed:
Hospice Medical Director Signature:	Date Physician Signed:

To submit this form electronically after completion visits the Qualis Health Provider Portal at www.qualishealth.org. Then select one of the choices in the Healthcare Professional Drop-Down Menu: DC Medicaid or Provider Resources. You can obtain additional assistance in registering for the Qualis Health Provider Portal by contacting ProviderPortalHelp@qualishealth.org.