HOSPICE RECIPIENT STATUS CHANGE

DATE:_____

Provider Name _____

Medicaid Provider Number_____ **NPI Number** _____

Address _____

_____

Contact Name _____

Contact Phone_____ **Contact Fax** _____

The following change information is being routed for review and processing:

Recipient Name _____

Medicaid Number_____ **Last four digits of SSN** _____

Revocation or Discharge of Hospice Benefit Date_____

Reason for Revocation or Discharge _____

Dually Eligible Institutionalized Recipient

- ❑ **Initial NH Admit**
  Date of Admission _____
  Name of NH_____
- ❑ **Discharged from NH to Hospital**
  Effective Date _____
- ❑ **Discharged from NH to Community**
  Effective Date _____
- ❑ **Expired in NH**
  Effective Date _____
- ❑ **Readmitted to NH from Hospital**
  Effective Date _____
- ❑ **Discharged from Hospice to NH**
  Effective Date_____

Medicaid Only Recipient

- ❑ **Readmission after Unrelated Hospital Stay**
  Effective Date _____
- ❑ **Discharge/Revoke/Death**
  Effective Date _____
- ❑ **Discharged from NH to Hospital**
  Effective Date _____
- ❑ **Discharged from NH to Community**
  Effective Date _____
- ❑ **Expired in NH**
  Effective Date _____
- ❑ **Discharge to Hospital for Unrelated Stay**
  Effective Date _____