HOSPICE RECIPIENT STATUS CHANGE

DATE: _____

Provider Name _____

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 _____ **Social Security Number** _____

Revocation or Discharge of Hospice Benefit **Date** _____

Reason for Revocation or Discharge _____

_____

_____

Dually Eligible Institutionalized Recipient

- ❑ **Initial NH Admit**
  Date of Admission _____
- ❑ **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 _____

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 _____