

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 _____

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