MEDICAID HOSPICE PHYSICAN CERTIFICATION / RECERTIFICATION

RECIPIENT INFORMATION:

NAME: LAST FIRST			MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:

HOME PHONE NUMBER (INCLUDE AREA CODE):	BIRTH DATE:
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::	MEDICAID PROVIDER NUMBER OF NURSING FACILITY::
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:
NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR

PHYSICIANS, PLEASE SIGN AND DATE TO INDICTATE CERTIFICATION.

FIRST BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF ATTENDING PHYSICIAN	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

Second BENEFIT PERIOD (90 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

_______ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

_______ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

_______ BENEFIT PERIOD (60 DAYS):

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

DHHS FORM 151 (10/96) (REVISED 06/08) Forward a copy of this form and a copy of the plan of care within then (10) working days of the beginning of each benefit period to the SCDHHS Medicaid Hospice Program. Failure to submit this form within the given time frame may result in delay or loss of payment for hospice service