MARYLAND MEDICAL ASSISTANCE PROGRAM
HOSPICE E-REQUEST FORM

TO: **Office of Long Term Services and Supports**
MDH Hospice mdh.hospice@maryland.gov

FROM: Provider Name ______ Provider Number ______

Authorized Representative ______ Title ______

Phone Number ______ Email address ______

Participant Name ______ Medicaid # ______

I, the authorized hospice representative, certify that the following documents have been obtained and/or completed and will be made available to the Maryland Department of Health upon request.

- ☐ Hospice Election Declaration
- ☐ Revocation Statement
- ☐ Long Term Care Patient-Medicaid Hospice Election Report
- ☐ Change of Hospice Designation
- ☐ Notice of Eligibility
- ☐ Written medical certification

Please check which action(s) is (are) being requested and complete all the fields in the area(s) indicated.

☐ **Initial Enrollment**

Effective date of enrollment ______ Diagnosis: ______

Living in a nursing facility ☐ Name of nursing facility ______

Attending physician ______ Last date for nursing facility to bill Medicaid ______

☐ **Change in Hospice Care Provider** Effective Date ______

Name of New Provider ______

☐ **Change in Recipient Resources** Effective Date ______

New amount ______ **Please attach copy of Notice of Eligibility

☐ **Revocation of Hospice Care Election by Participant** Effective Date ______

Reason for revocation ______

** Please submit a copy of the revocation statement

☐ **Termination of Hospice Care due to Death of Recipient** Date of Death ______

☐ **Termination of Hospice Care Election for Cause** Effective Date ______

Recommend termination for the following reason (documentation must be attached) ______

Enter any additional information you believe pertinent to this request in the box below.

______

I hereby certify that the above statements are true to the best of my knowledge.

Signature ______ Date ______

Revised 08/2019