

Mississippi Medicaid Hospice Forms



Go to : [HealthSystems of Mississippi \(HSM\)](http://www.hsom.org) and select the link www.hsom.org for

Hospice Provider Manual submission instructions.

HealthSystems of Mississippi

Questions: Phone Toll Free 1-866-740-2221

Instructions for Completing the Mississippi Medicaid Hospice Election Package:

Election Package includes:

- A. Election Statement Form 1165-A
- B. Enrollment Form 1165-B
- C. Physician Certification Form 1165-C (90-90-60 day Benefit Periods)

A. Instructions for Completing Election Statement Form 1165-A

1. **Beneficiary Name** - Complete the individual's name **exactly** as it appears on his/her Medicaid card.
2. **Beneficiary Medicaid Number** - Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.
3. **Address** - Beneficiary's Street Address, City, State and Zip Code.
4. **Beneficiary/Legal Guardian/Representative's Signature** - Complete if applicable.
5. **Provider Signature (Must be present)**
6. **Provider Name**
7. **Medicaid Provider Number/NPI Number**

Election Statement Form



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The Mississippi Medicaid Hospice Care Services program has been explained to me. I have been given the opportunity to discuss the benefits, requirements, and limitations of this program and the terms of the election statement. I understand that by signing the election statement, I am waiving all rights to Medicaid for the duration of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice) and;
2. Any Medicaid services that are related to the treatment of the condition, or a condition, for which hospice care was elected or that are equivalent to hospice care with the following exception:
 - a) Services provided (either directly or under arrangement) by the designated hospice.
 - b) Services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services).
 - c) Services provided as room, board, and services in a nursing facility if the beneficiary is a resident at the time the hospice election is made and Medicaid was paying for that service.

I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefit periods of an initial 90 days period, a subsequent 90 day period and unlimited subsequent 60 day periods.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.

I understand that I may change the designated hospice provider once each election period without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received.

Beneficiary Name (Last, First and Middle Initial)	Beneficiary Medicaid Number

Address (Street Address, City, State and Zip Code)

By signing this statement, I am electing the below named hospice to provide me with the services of the Medicaid hospice care program.

Beneficiary/Legal Guardian/Representative's Signature	Date

*Provider Signature (Must be present)	Date

Provider Name	Medicaid Provider #	NPI #

Below This Line For DOM Use Only

*The Hospice provider's representative, who is present, must sign as the witness.	

Mississippi Medicaid Hospice Enrollment Form

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B. Instructions for Completing the Mississippi Medicaid Hospice Enrollment Form 1165-B:

1. Complete the individual's name **exactly** as it appears on his/her Medicaid card.
2. Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.
3. Complete the individual's Social Security number **exactly** as it appears on his/her Social Security card.
4. Complete the individual's Medicare number **exactly** as it appears on his/her Medicare card.
5. Complete the individual's date of birth.
6. Complete the individual's area code and phone number.
7. Complete the individual's street address.
8. Complete the individual's City, State, and Zip Code.
9. Complete the name of parent, legal guardian, or legal representative (if applicable).
10. Complete by checking the appropriate box for the hospice benefit period and fill in requested effective date of segment.
11. List the primary diagnosis, by ICD-9-CM code and list up to two secondary codes, if applicable.
12. Complete the hospice's Medicaid provider name.
13. Complete the hospice's Medicaid provider number and NPI number.
14. Complete the name of the nursing facility where the beneficiary resides (if applicable).
15. Complete the nursing facility's Medicaid provider number (if applicable).
16. Complete the attending physician's name and NPI number.
17. Complete the county where actual services will be rendered.
18. Have the provider's representative sign the form.
19. Have the provider's representative date the form.

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Beneficiary Information

1. Beneficiary Name (Last, First and Middle Initial)	
2. Beneficiary Medicaid #	3. Social Security #
4. Beneficiary Medicare ID #	5. Date of Birth
6. Home Phone Number	7. Street Address
8. City, State and Zip Code	
9. Parent/Legal Guardian or Representative	
10. Hospice Benefit Period:	
<input type="checkbox"/> First 90 Day Period	<input type="checkbox"/> Second 90 Day Period
<input type="checkbox"/> 60 Day Period	Requested effective date of period: _____
11. Diagnosis Code:	
Primary Code: _____	Secondary Code: _____
Secondary Code: _____	

Provider Information

12. Hospice Provider Name	13. Hospice Medicaid Provider #	Hospice NPI #
14. Nursing Facility Where Beneficiary Resides (if applicable)		
15. Nursing Facility Medicaid Provider # (if applicable)		
16. Attending Physician's Name	Medicaid ID # or NA	NPI #
17. Name of County Where Services Will Be Rendered		
18. Provider Signature	19. Date	

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C. Physician Certification Form DOM-1165-C (90-90-60 day Benefit Periods)

Please complete all applicable fields as indicated on Form DOM-1165-C with special instructions noted below:

1. Complete the individual's name **exactly** as it appears on his/her Medicaid card.
2. Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.
3. Complete the individual's Social Security number **exactly** as it appears on his/her Social Security card.
4. Complete the individual's Medicare number **exactly** as it appears on his/her Medicare card.
5. Complete address of individual where services will be rendered
6. Complete the name of the nursing facility where the individual resides (if applicable).
7. Complete the nursing facility's Medicaid provider number (if applicable).
8. Complete the name of parent, legal guardian, or legal representative (if applicable).
9. List the primary hospice diagnosis, by ICD-9-CM code.
10. Complete the hospice's Medicaid provider name and Medicaid provider number.
11. Complete the hospice's NPI number.
12. Complete the county where actual services will be rendered.
13. Place an X beside the appropriate Benefit Period and enter the "from and thru" dates.
14. Print the name of the attending physician; obtain the attending physician's signature, and NPI number.
15. The certification date is completed by the attending physician (the date the form is signed).
16. Print the name of the Hospice Medical Director; obtain the Hospice Medical Director's signature and NPI number (for each benefit period).
17. The certification date is completed by the Hospice Medical Director (the date the form is signed).



MISSISSIPPI MEDICAID HOSPICE PHYSICIAN 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-CM NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	
NAME OF HOSPICE:			
ADDRESS:		NPI NUMBER:	
COUNTY WHERE SERVICES RENDERED:		MEDICAID PROVIDER NUMBER:	

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

First BENEFIT PERIOD (90 DAYS): From _____ Thru _____
 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.

PRINT NAME	CERTIFICATION DATE
SIGNATURE OF ATTENDING PHYSICIAN	NPI #
PRINT NAME	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	NPI #

Second BENEFIT PERIOD (90 DAYS): From _____ Thru _____
 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.

PRINT NAME	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	NPI #

____ BENEFIT PERIOD (60 DAYS) From _____ Thru _____
 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. **(ATTACH FACE TO FACE ENCOUNTER FOR THIS & SUBSEQUENT PERIODS)**

PRINT NAME	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	NPI #

Before Submitting to HealthSystems of Mississippi:
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