MAP-397
(Rev. 12/11)

HOSPICE
OTHER SERVICES STATEMENT

This is to certify that the service(s) checked below provided by

Name of Agency:		
Recipient Name:		DOB:
Member ID:	SSN:	
Date of Service:	**NOT** related in any way to the terminal illness of this patient.	
The reason for service(s):		
Diagnosis:		ICD-9 CM:
Diagnosis:		ICD-9 CM:
Terminal Diagnosis:		ICD-9 CM:

Charges for this/these services should not be billed to the hospice agency but should be billed directly to the KY Medicaid Program.

Medical Director Signature _____ Date _____

Hospice Agency Information

Hospice Agency:	Telephone #:
Medicaid Provider #:	Fax#:

☐ **Durable Medical Equipment List**:

☐ **Hospital Outpatient Services (Describe Service/Reason or attach supporting documentation))**

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HOSPICE
OTHER SERVICES STATEMENT

Provide or attach documentation verifying that hospitalization is NOT related to terminal illness.

First time patient has required service(s) NOT related to the terminal illness? ☐Yes ☐No

Previous service(s) for conditions NOT related to terminal illness		
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:
Date:	**Diagnosis:**	ICD-9 CM:

*All sections above the approval line must be complete prior to review.

☐Approved by the Medicaid Program ☐Denied by the Medicaid Program

Medicaid/Reviewer Signature/Title _____ Date _____

CLEAR FORM