AmeriHealth Caritas Louisiana

PATIENT INFORMATION		
Patient's Name (First, Middle Initial, Last)	Patient's Medicaid ID # (13-digits)	Patient's Date of Birth (MM-DD-YYYY)

FIRST BENEFIT PERIOD (90 Days)

Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Attending Physician	Date Signed (MM-DD-YYYY)
Printed Name of Above Attending Physician	
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

SECOND BENEFIT PERIOD (90 Days)

Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

THIRD BENEFIT PERIOD (60 Days)

Having reviewed this patient's Medical record and/or Examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

REFFERING PHYSICIAN NARRATIVE STATEMENT:

Review of the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services. Narrative must be written legible by the physician.

SIGNATURES (Physicians must date at time of signature)

Signature Referring Physician	Date Signed (MM-DD-YYYY)
Printed Name of Above Physician	

NOTE: If additional periods are to be certified, use an additional form

VERBAL VERIFICATION (within two days of election date)

I certify that on the date signed below a verbal verification was obtained from the physician named below; confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

SIGNATURES

Physician's Name **(printed)**		
Signature of IDG Member Taking Referral	Printed Name of IDG Member Taking Referral	Date Signed (MM-DD-YYYY)

THIS FORM CANNOT BE ALTERED

Please return to ACLA's Utilization Management department via fax to: 1-866-397-4522.