AmeriHealth Caritas Louisiana

PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY

1 **Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting**

_____
Election/Admission Date (MM-DD-YYYY)

NOTE: To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

PATIENT'S STATEMENT

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better. I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

SIGNATURES

Signature of Patient/Legal Representative	Date of Signed (MM-DD-YYYY)	Representative's Daytime Phone # (incl. area code)
Printed Name of Above Signee	Legal Representative's Relationship to Patient	

PART II: TO BE COMPLETED BY HOSPICE PROVIDER

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)	Patient's Address City State Zip	
Patient Medicaid ID #	Patient Medicare ID #	Date of Birth (MM-DD-YYYY)

Type Bill	Statement Covers Period From (MM-DD-YYYY)	Statement Covers Period Through (MM-DD-YYYY)	Primary Diagnosis Code (s)	List All Other Diagnosis Codes

Discharge/Revocation Reason(s):

PROVIDER INFORMATION

Hospice Provider Name		Hospice Address	
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)	Hospice City State Zip	
Attending Physician Printed Name		Attending Physician Provider #s	Hospice Relationship Status

SIGNATURES

Hospice Provider Representative's Signature	Hospice Representative's Printed Name	Date (MM-DD-YYYY)

This form cannot be altered.

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