AmeriHealth Caritas Louisiana

Hospice Care for Members Younger Than Age 21

Part I: To be completed by patient or legal representative only

I choose to receive services from the hospice provider named below starting:

Election/admission date (MM/DD/YYYY):

NOTE: To receive hospice services, my doctor must determine that I am in my final stages of life.

Patient's statement

I understand and accept:

- I can receive hospice service for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- I may request Concurrent Care Hospice and receive life-prolonging therapies.
- If my illness improves, I must discontinue hospice services under the Medicaid program. If I no longer receive hospice services, I can continue using Medicaid for other services.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- My signature certifies that I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose not to receive hospice care at any time.

Please select your preferred type of Hospice Care: ☐ Concurrent Care Hospice ☐ Traditional Hospice

Signatures

Signature of patient/legal representative:	
Date signed (MM-DD-YYYY):	Representative's daytime phone:
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):	Patient's current age:	
Type bill:	Statement covers period from (MM-DD-YYYY):	through (MM-DD-YYYY):
Primary diagnosis code(s):		
List all other diagnosis codes:		
Discharge/revocation reason(s):		

Provider information

Hospice provider name:	Hospice provider #:	
Hospice provider phone:	Hospice provider fax:	
Hospice address:		
City:	State:	Zip:
Attending physician printed name:		
Attending physician provider #:	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.