



Texas Medicaid Hospice Program
Individual Election/Cancellation/Update

1. Form Type <input type="checkbox"/> 1 = Election <input type="checkbox"/> 2 = Update <input type="checkbox"/> 3 = Correction <input type="checkbox"/> 4 = Cancel		2. Cancel Code	3. From (MMDDYYYY)	4. To (MMDDYYYY)
5. Setting <input type="checkbox"/> 1 = Home <input type="checkbox"/> 2 = NF <input type="checkbox"/> 3 = Hospital <input type="checkbox"/> 4 = Hospice Inpatient Unit <input type="checkbox"/> 5 = ICF/IID <input type="checkbox"/> 6 = SNF				6. Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Name of Individual (Last, First, Middle)		8. Medicaid No.	9. Social Security No.	10. Date of Birth (MMDDYYYY)
11. Name of Facility/Provider and Address of Individual (Street, City, State, ZIP)				12. County

All Terminal Diagnoses -- List all Terminal Illnesses	ICD Code
	13.
	14.
	15.
	16.

Provider Information

17. Enter Comments		
18. Hospice Name	19. Contract No.	20. Area Code and Telephone No.
21. Hospice Address (Street, City, State, ZIP)		
22. Attending Physician's Name	23. State License No.	24. Date of Orders (MMDDYYYY)

Keep a copy for your files

25. Printed Name of Hospice Provider Representative	_____	_____
	26. Signature - Hospice Representative	27. Date (MMDDYYYY)

Individual's Declaration

I understand if I am determined eligible for Medicaid, I may receive Medicaid hospice services such as physician care services, nursing care services, medical social services, counseling services, home health aide services, therapy services, medical appliances and supplies, drugs and biologicals, volunteer services, inpatient services, respite services and other services related to the treatment of my terminal condition for which hospice care was elected.

I waive other Medicaid acute care services related to the treatment of my terminal illness(es). I do not waive Medicaid services unrelated to the treatment of my terminal illness(es). I waive only those Medicaid services also provided by Medicare. Individuals under 21 years of age are not required to waive Medicaid services.

I understand I must elect the Medicare and Medicaid hospice programs when I am eligible for both Medicare and Medicaid benefits.

I understand I may cancel and re-elect the Medicaid Hospice Program at any time without any penalties.

I understand the difference between palliative and curative care.

_____	_____
28. Signature - Individual	29. Date (MMDDYYYY)