State of New Hampshire
Department of Health & Human Services
Office of Medicaid Business and Policy

Form 282A
07/2010

Medicaid Hospice Care Notification Form
Election, Change in Designated Hospice, Revocation, Death

Please Check all Appropriate Boxes

[ ] Election of Medicaid Hospice
  [ ] Recipient also has Medicare
  [ ] If recipient has Medicare, recipient has elected the hospice benefit under Medicare
  [ ] Recipient is covered under another insurance with a hospice benefit

  List Insurance: _____

[ ] Revocation of Medicaid Hospice
  [ ] Recipient also has Medicare
[ ] Change in Designated Hospice

[ ] Date of Death: _____

Effective Date of Election of Hospice Care Benefit (per provider's election form):_____
Start date of Medicaid Hospice Care Benefit by Hospice Provider:_____

Provider Information

Hospice designated by recipient: _____Medicaid Provider Number: _____
Address: _____
Phone Number: _____
Attending Physician: _____
Name of Nursing Facility in which Recipient Resides (if applicable): _____

Recipient Information

Name of Recipient: _____ D.O.B.: _____
Address: _____
Diagnosis: _____ Medicaid Number_____
Prognosis: _____
Name of agent or legal guardian (if applicable): _____

Hospice Benefit Information Election Period (circle one)

1st Period (90 days) 2nd Period (90 days) Unlimited number of 60 day periods:

1st 60 days 2nd 60 days 3rd 60 days 4th 60 days

Change in Designated Hospice

Effective Date: _____
Name of Current Hospice: _____ Phone: _____
Address: _____
Name of New Hospice: _____ Phone: _____
Address: _____

Revocation of Hospice

Effective Date of Revocation: _____
Date eligible for future Hospice Benefit: _____

Please forward this information by fax or mail to the Office of Medicaid Business and Policy
129 Pleasant Street**.** Brown Building.Concord, NH 03301.Fax (603) 271-8194. Phone (603) 271-5219