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**CHAPTER 24: HOSPICE**

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**APPENDIX A: BENEFICIARY NOTICE OF  
ELECTION/REVOCATION/DISCHARGE/TRANSFER**

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**BENEFICIARY NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER****Purpose of Form**

The BHSF Form Hospice–Notice of Election (NOE) is used to notify the Hospice Prior Authorization Unit (PAU) of a hospice beneficiary’s voluntary election or cancellation of the Hospice Program.

This form is also used to update changes in the beneficiary’s condition and status.

Upon completion, the form along with the CTI, physician narrative, and all related documentation must be sent to:

**Gainwell Technologies via the e-PA system  
@Lamedicaid.com**

**NOTE:** Electronic submissions are required due to the time-frames.

**Notifications and Type of Bill**

The alpha character for the third digit of the BHSF Form Hospice – Notice of Election’s field titled “Type of Bill” is used to indicate the type of notification that is being provided.

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Notification	Type Bill	Description
Notice of Election (NOE)	81A/82A	When a beneficiary elects Medicaid hospice care, the beneficiary must sign and date the BHSF Form Hospice - Notice of Election. The hospice provider is required to submit this form as a Notice of Election (NOE) immediately after obtaining the receipt and receipt of the physician's completed BHSF Form Hospice – TI (Certification of Terminal Illness), including verbal certification where applicable. Both the forms, properly completed must be received by the Hospice Program within 10 calendar days following the initiation of hospice care. If this requirement is not met, reimbursement is not available for the days prior to receipt of the forms. Reimbursement will become effective the date the hospice PAU receives the proper documentation.
Notice of Termination	81B/82B	This notice is used for a beneficiary who has revoked/discharged from a hospice election period. This must be sent to the Hospice PAU within five calendar of discharge or revocation. For revocation, a signed written statement by the beneficiary or legal representative must accompany the form with 81/B noted. In addition, the beneficiary's or legal representative's contact information must be provided.
Notice of Change (Transfer)	81C/82C	A Notice of transfer is sent when the beneficiary is in the middle of an election period and wants to change hospice providers. <b>A beneficiary may change hospices once each election period.</b> The date of discharge from the current hospice must ideally be only one day before the date of admission to the newly designated hospice. These providers must communicate with each other to decide how the coordination of the beneficiary's hospice care will be handled. The first hospice should send the beneficiary's history and Plan of Care (POC) to the new hospice. The first hospice must submit the notice of transfer to the hospice PAU within five calendar days after receipt of the filed notice of change statement. The new hospice provider

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Notification	Type Bill	Description
		must submit the Notification of Transfer (81C/82C) to the Hospice PAU within five calendar days of transfer. The date of admission on the Notification of Transfer should be the date the beneficiary was admitted into the new hospice.  <b>NOTE:</b> An 81C/82C must also be sent to the Hospice PAU when a beneficiary is transferring to or from a nursing facility.
Notice of Void (of a NOE)	81D/82D	This notice is used to void an 81A/82A that was established in error, such as if the beneficiary changes his/her mind, or if the wrong Date of Admission was previously submitted. Please note: A notice of void will not be honored if submitted to avoid payments to non-hospice providers. Notice of Voids must be submitted within five calendar days.  <b>NOTE:</b> If claims have processed during the voided election period, claims must be voided before 81D/82D is submitted and a recoupment made to the intermediary.

**Instructions for Completing the BHSF Form Hospice-Notice of Election****Completing the BHSF Form Hospice****PART I**

The first section of the form (PART I) is to be completed by the beneficiary or legal representative only. The signature of the beneficiary or legal representative is required. The beneficiary or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. **The legal representative must show relationship to the beneficiary and provide contact information.**

**1. Election/Admission Date - REQUIRED**

The date of admission cannot precede the physician's certification by more than two calendar days, and is the same as the certification date if the certification is not completed on time. The date must be entered by the beneficiary or legal representative. Hospice providers are prohibited from entering information in this field.

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**NOTE:** If the BHSF Form Hospice -Notice of Election form and the Certification of Terminal Illness are not received within ten calendar days of the initiation of hospice care, the date of admission (election) will be the date the Hospice PAU receives the proper documentation. This rule applies to beneficiaries receiving Medicaid only, as well as Medicaid/Medicare (dual eligible) beneficiaries.

**EXAMPLE:** The hospice election date (admission) is January 1, 2019. The physician's certification is dated January 3, 2019. The hospice date for coverage and billing is January 1, 2019. The first hospice benefit period ends 90 days from January 1, 2019. However, if the required forms and completed packet is not received within the ten calendar day timeframe, the benefit begin date will be the date the completed packet is received by the hospice PAU. For example, if the required forms and completed packet are received on January 11, 2019, the begin date would be January 11, 2019.

The admission date will change when the beneficiary re-elects hospice any time after a revocation or discharge.

**2. Signature of Patient/Legal Representative – REQUIRED**

The signature of the beneficiary or legal representative is required. The beneficiary or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. The date of signature will become the LDH approval date if signed after the admission date.

In cases where a beneficiary signs the Notice of Election form with an “X”, there must be two witnesses to sign next to the beneficiary’s mark. The witnesses must also indicate relationship to the beneficiary and daytime phone number. One witness must be a relative or legal representative. Hospice representatives cannot sign as a witness.

**Definition of Relative**

A relative is defined as all persons related to the beneficiary by virtue of blood, marriage, adoption or legal guardians as court appointed.

**Non-Relatives**

Persons other than relatives signing the BHSF Form Hospice-Notice of Election must have legal rights, (a medical power of attorney) to make medical decisions for beneficiaries who are physically or mentally incapacitated. Proof of these rights must be notarized or court issued

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documents and submitted at the time the election for hospice is made. Verbal elections are prohibited.

**3. Date of Signed - REQUIRED**

The beneficiary or legal representative must enter date at time of signature.

**4. Representative's Daytime Phone Number - REQUIRED**

The legal representative must provide his/her contact information including the area code.

**5. Printed Name of Above Signee – REQUIRED**

The person who signed acknowledgement of Patient's Declaration must also print name. This could be the beneficiary or the authorized representative, whichever has signed.

**6. Legal Representative's Relationship to Patient - REQUIRED**

The legal representative must show relationship to the beneficiary. If the legal representative is not related to the beneficiary, follow the instructions as outlined in number 2 above.

**PART II**

The second section of the form (**PART II**) is to be completed by the hospice provider.

**NOTE:** When revoking hospice services, the beneficiary or legal representative must, in their own handwriting, complete the reason for revocation.

**Patient Information****7. Patient Name - REQUIRED**

Enter the beneficiary's first name, middle initial and last name in this order as it is printed on the beneficiary's Medicaid card.

**8. Patient Address - REQUIRED**

Enter the beneficiary's complete mailing address, including zip code.

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**9. Patient Medicaid ID Number - REQUIRED**

Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears in the beneficiary's current Medicaid information using the plastic Medicaid "swipe" card, e-MEVS, or REVS. Make certain that the last two digits are the correct individual suffix for your beneficiary. The number must match the beneficiary's name. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

**NOTE:** Providers enrolling patients with "Pending" ID numbers are assuming responsibility for those patients. **It is the provider's responsibility to notify the hospice PAU when beneficiaries have been approved for Medicaid.**

**10. Patient Medicare ID Number – REQUIRED, IF APPLICABLE**

This field should only be used if the beneficiary has Medicare. Enter the beneficiary's Medicare health insurance number.

**11. Patient Date of Birth - REQUIRED**

Enter the month, day and year of birth (MM-DD-YYYY) of beneficiary. Example: 06-12-1903.

**12. Type Bill - REQUIRED**

**Enter the three-digit numeric type of bill code, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third is referred to as a "frequency" code and it indicates the sequence of this bill in this particular episode of care.**

Code Structure:

1st Digit - Type of Facility  
8 - Special facility (hospice)

2nd Digit - Classification  
1 - Hospice (Non-hospital based)  
2 - Hospice (Hospital based)

3rd Digit - Frequency  
A - Hospice Admission Notice

Definition  
Use when the hospice is submitting form as an admission notice.

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B - Hospice Termination/ Revocation Notice	Use when the hospice is submitting form as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when form is used as a notice of change in the hospice provider or nursing facility.
D - Hospice Election Void/Cancel	Use when form is used as a notice of a void/cancel of hospice election.
E - Hospice Change of Ownership	Use when form is used as a notice of change in ownership for the hospice.

**13. Statement Covers Period – REQUIRED, IF APPLICABLE**

This field is to be used when filing an 81B/82B document and upon the initial election of hospice only. The “From” date is the start date of the period from which the beneficiary is revoking. The “Through” date is the date of revocation. Dates must be entered numerically as MM-DD-YYYY. “From” date must match the date the beneficiary/legal representative elects the hospice service.

**14. Primary Diagnosis Code(s) - REQUIRED**

Use the most specific and accurate numeric ICD-10-CM diagnosis code(s) for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the beneficiary’s admission. CMS only accepts ICD-10-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-10-CM Coordination and Maintenance Committee. Use full ICD-10-CM or its successors’ diagnoses codes including all five digits where applicable.

**15. List All Other Diagnosis Codes - REQUIRED**

Enter the full ICD-10 or its successors’ codes, including all five digits where applicable, for any other terminal diagnosis and **or related condition. List ALL co-morbidities.**

**16. Discharge/Revocation Reason(s) - REQUIRED:**

Enter the reason(s) for the discharge or revocation. Beneficiary or legal representative must sign and date NOE form if the beneficiary is revoking hospice services.

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The beneficiary or legal representative must also provide a statement for the reason of revoking services.

The hospice provider must sign and date if the beneficiary is discharging. The hospice provider must also provide the reason the beneficiary is being discharged.

Forms received after the specified time limits will become effective upon date of receipt.

**Provider Information****17. Hospice Provider Name - REQUIRED**

Enter the hospice provider name.

**18. Hospice Address - REQUIRED**

Enter the hospice provider address (street number and name, city, state, and zip code).

**19. Hospice Provider Number - REQUIRED**

Enter the seven-digit Medicaid provider identification number.

**20. Hospice Provider Telephone Number – REQUIRED**

Enter the hospice provider telephone number including area code. Fax number is optional.

**21. Name of Nursing Facility or ICF-ID – REQUIRED, IF APPLICABLE**

Enter the name of the facility in which the beneficiary resides or intends to reside. Medicaid field office staff determines long-term care eligibility.

**22. Attending Physician Printed Name - REQUIRED**

Print the name of the attending physician currently responsible for referring, certifying, and signing the individual's plan of care for medical care and treatment.

**NOTE:** The attending physician's name must be the same on the NOE and CTI.



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**23. Attending Physician Provider Number - REQUIRED**

Enter the attending physician's seven digit Medicaid provider identification number.

**24. Hospice Relationship Status - REQUIRED**

Enter the word "employee" or "non-employee" here to describe the relationship the beneficiary's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

**25. Hospice Provider's Representative's Signature – REQUIRED**

Signature required.

**26. Hospice Provider's Representative's Printed Name – REQUIRED**

Printed name required.

**27. Date – REQUIRED**

Hospice representative must enter date at time of signature.

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Department of Health and Hospitals  
Louisiana Medicaid Hospice Program

## RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

## 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 **1**

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 **2** Date of Signed (MM-DD-YYYY) **3** Representative's Daytime Phone # (incl. area code) **4**Printed Name of Above Signee **5**Legal Representative's Relationship to Patient **6**

## PART II: TO BE COMPLETED BY HOSPICE PROVIDER

## PATIENT INFORMATION

Patient Name (First, Middle Initial, Last) **7** Patient's Address **8** City State ZipPatient Medicaid ID # **9**Patient Medicare ID # **10**Date of Birth (MM-DD-YYYY) **11**Type Bill **12**Statement Covers Period  
From (MM-DD-YY) **13** Through (MM-DD-YY)Primary Diagnosis Code (s) **14**List All Other Diagnosis Codes **15**Discharge/Revocation Reason(s): **16**

## PROVIDER INFORMATION

Hospice Provider Name **17** Hospice Address **18** City State ZipHospice Provider # **19**Hospice Provider Phone # (incl. area code & Fax) **20**Name of Nursing Facility or Intermediate Care Facility (ICF-DD) **21**Attending Physician Printed Name **22**Attending Physician Provider #s **23**Hospice Relationship Status **24**

## SIGNATURES

Hospice Provider Representative's Signature **25**Hospice Representative's Printed Name **26**Date (MM-DD-YYYY) **27**

## Department of Health and Hospitals

## Louisiana Medicaid Hospice Program

## RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

**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) Through (MM-DD-YYYY)		Primary Diagnosis Code (s)	List All Other Diagnosis Codes		
Discharge/Revocation Reason(s):						

**PROVIDER INFORMATION**

Hospice Provider Name		Hospice Address		City	State	Zip
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)		Name of Nursing Facility or Intermediate Care Facility (ICF-DD)			
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)
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