RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

Purpose of Form

The BHSF Form Hospice–Notice of Election (NOE) is used to notify the Hospice PAU of a hospice recipient's voluntary election or cancellation of the Hospice Program.

This form is also used to update changes in the recipient's condition and status.

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

Molina Medicaid Solutions 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:

Notification	Type Bill	Description
Notice of Election (NOE)	81A/82A	When a recipient elects Medicaid hospice care, the recipient 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.

Notification	Type Bill	Description
Notice of Termination	81B/82B	This notice is used for a recipient who has revoked/discharged from a hospice election period. This must be sent to the Hospice Program within 48 hours of discharge and within 72 hours of revocation. For revocation, a signed written statement by the recipient or legal representative must accompany the form with 81/B noted. In addition, the recipient's or legal representative's contact information must be provided.
Notice of Change (Transfer)	81C/82C	A Notice of transfer is sent when the recipient is in the middle of an election period and wants to change hospice providers. **A recipient may change hospices once each election period**. 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 recipient's hospice care will be handled. The first hospice should send the recipient's history and Plan of Care (POC) to the new hospice. The first hospice must submit the notice of transfer to the hospice manager within two working days after receipt of the filed notice of change statement. The new hospice provider must submit the Notification of transfer (81C/82C) to the Hospice PAU within 48 hours of transfer. The date of admission on the Notification of transfer should be the date the recipient was admitted into the new hospice. **NOTE:** An 81C/82C must also be sent to the Hospice PAU when a recipient 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 recipient 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 two working days. **NOTE:** 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 recipient or legal representative only. The signature of the recipient or legal representative is required. The recipient 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 recipient 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 recipient or legal representative. Hospice providers are prohibited from entering information in this field.

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 recipients receiving Medicaid only, as well as Medicaid/Medicare (dual eligible) recipients.

EXAMPLE: The hospice election date (admission) is January 1, 2016. The physician's certification is dated January 3, 2016. The hospice date for coverage and billing is January 1, 2016. The first hospice benefit period ends 90 days from January 1, 2016. However, if the required forms and completed packet is not received within the ten-day timeframe (e.g. January 11, 2016), the benefit begin date will be the date the completed packet is received by the hospice PAU, in this case the begin date would be January 11, 2016.

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

2. Signature of Patient/Legal Representative – REQUIRED

The signature of the recipient or legal representative is required. The recipient 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 recipient signs the Notice of Election form with an "X", there must be two witnesses to sign next to the recipient's mark. The witnesses must also indicate relationship to the recipient and daytime phone number. One witness must be a relative or legal representative. Hospice representative cannot sign as a witness.

Definition of Relative

A relative is defined as all persons related to the recipient 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 recipients who are physically or mentally incapacitated. Proof of these rights must be notarized or court issued documents and submitted at the time the election for hospice is made. Verbal elections are prohibited.

3. Date of Signed - REQUIRED

The recipient 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 recipient or the authorized representative, whichever has signed.

6. Legal Representative's Relationship to Patient - REQUIRED

The legal representative must show relationship to the recipient. If the legal representative is not related to the recipient, 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 recipient or legal representative must, in their own handwriting, complete the reason for revocation.

Patient Information

7. Patient Name - REQUIRED

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

8. Patient Address - REQUIRED

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

9. Patient Medicaid ID Number - REQUIRED

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient'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 recipient. The number must match the recipient'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 recipients have been approved for Medicaid.**

10. Patient Medicare ID Number – REQUIRED, IF APPLICABLE

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

11. Patient Date of Birth - REQUIRED

Enter the month, day and year of birth (MM-DD-YYYY) of recipient. 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	Definition
A - Hospice Admission Notice	Use when the hospice is submitting form as an admission notice.
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 recipient 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 recipient/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 recipient's admission. CMS only accepts ICD-10-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-l260 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 diagnoses codes including all five digits where applicable.

15. List All Other Diagnosis Codes - REQUIRED

Enter the full ICD-10 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. Recipient or legal representative must sign and date NOE form if the recipient is revoking hospice services.

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

The hospice provider must sign and date if the recipient is discharging. The hospice provider must also provide the reason the recipient 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 recipient 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.

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 recipient'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.

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 Zip	
Patient Medicaid ID # 9	Patient Medicare ID # 10	Date of Birth (MM-DD-YYYY) 11
Type Bill 12	Statement Covers Period From (MM-DD-YYYY) 13 Through (MM-DD-YYYY)	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 Zip	
Hospice 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

Reissued March 2012 Prior Issues Obsolete **This form cannot be altered.** BHSF Form Hospice-NOE

LOUISIANA MEDICAID PROGRAM **ISSUED: 11/29/16**

Department of Health and Hospitals
Louisiana Medicaid Hospice Program
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Printed Name of Above Signee	Legal Representative's Relationship to Patient	

PART II: TO BE COMPLETED BY HOSPICE PROVIDER

PATIENT INFORMATION

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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 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)