
CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5****CERTIFICATION OF TERMINAL ILLNESS****Instructions for Completing the BHSF Form Hospice-Certification of Terminal Illness****Purpose of BHSF Form Hospice-CTI**

The purpose of the BHSF Form Hospice Certification of Terminal Illness (CTI) is to document written and verbal certification of terminal illness for Medicaid beneficiaries. Additionally, this form may be utilized for dual eligible (Medicare/Medicaid) beneficiaries.

NOTE: This form is not to be altered by the Hospice provider.

The CTI, BHSF Form Hospice-Notice of Election (NOE) and all related documents must be electronically submitted via electronic prior authorization (e-PA) system (See Appendix C for contact information.)

Completing the BHSF Form Hospice-CTI

For Medicaid-only beneficiaries, there must be two different signatures on the CTI. For dual eligible (Medicare Part A) beneficiaries, only one physician's signature is necessary.

Submission of the physician's CTI is required all election periods. However, additional copies of certification forms for all election periods must be made available to the Bureau upon request.

NOTE: A stamped physician's signature is not acceptable on the certification. The physician must date this form at time of his signature. No stamped dates are acceptable. Submitting forms incorrectly may delay the hospice segment being added to the system. If the physician forgets to date the certification; another signed and dated CTI can be obtained to verify when the certification was obtained. The hospice approval date will be the date the signed and dated CTI is received in the hospice program office if submitted beyond the ten-day time limit.

Patient Information**1. Patient Name - REQUIRED**

Enter the beneficiary's first name, middle initial and last name in this order.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5****2. 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, electronic Medicaid eligibility verification system (e-MEVS), or the beneficiary eligibility verification system (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.

3. Patient's Date of Birth - REQUIRED

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

Certification of Terminal Illness

For the first benefit period (90 days) both attending physician and the hospice medical director or the physician member of the interdisciplinary group (IDG) must certify terminal illness.

Subsequent benefit periods (2nd, 3rd, 4th, etc.) require only the signature of the hospice medical director or the physician member of the IDG must certify terminal illness.

First Benefit Period (90 days)**4. Signature of Attending Physician - REQUIRED**

This is the signature of the attending physician prior to electing hospice and currently responsible for referring, certifying and signing the individual's plan of care for medical care and treatment.

5. Date Signed (MM-DD-YYYY) - REQUIRED

The attending physician must enter the date at the time of signature.

6. Printed Name of Above Attending Physician - REQUIRED

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

7. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED

This is the signature of the hospice medical director or physician member of IDG.

8. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDG must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5****9. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED**

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 7.

Second Benefit Period (90 Days)**10. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDG.

11. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDG must enter the date at the time of signature.

12. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 10.

Third Benefit Period (60 Days)**13. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDG.

14. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDG must enter the date at the time of signature.

15. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 13.

Referring Physician Narrative Statement**16. Narrative Statement - REQUIRED**

The attending/referring physician must complete a narrative providing the diagnosis, prognosis and the justification for hospice care. The narrative must be completed prior to the election of hospice care. The physician's signature is required.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5**

The narrative must include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the beneficiary's medical record or, if applicable, his or her examination of the patient.

17. Signature of the Referring Physician - REQUIRED

This is the signature of the referring physician.

18. Date Signed (MM-DD-YYYY) - REQUIRED

The referring physician must enter the date at the time of signature.

19. Printed Name of the Referring Physician - REQUIRED

Print the name of the referring physician who signed in as per number 17.

NOTE: If additional periods are to be certified, use an additional form.

Verbal Verification (within two days of election date)

This section must be used to document that verbal verification was obtained from the physician as named in this section confirming the recipient's prognosis of life expectancy of six months or less if the terminal illness runs its course. Either the verbal or written certification must be obtained within two days of the election date so hospice care can begin.

20. Printed Name of Physician Who Gave Verbal Verification - REQUIRED

Print the name of the physician who gave verbal verification of the recipient's terminal illness.

21. Signature of the IDG Member Taking Referral - REQUIRED

This is the signature of the member of the IDG who obtained the physician's verbal certification of terminal illness.

22. Printed Name of IDG Member Signee Taking Referral - REQUIRED

Print the name of the IDG who signed in as per number 21.

23. Date Signed (MM-DD-YYYY) - REQUIRED

The IDG member must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS

PAGE(S) 5

**Department of Health and Hospitals
Louisiana Medicaid Program
HOSPICE CERTIFICATION OF TERMINAL ILLNESS**

PATIENT INFORMATION		
Patient's Name (First, Middle Initial, Last) 1	Patient's Medicaid ID # (13-digits) 2	Patient's Date of Birth (MM-DD-YYYY) 3
FIRST BENEFIT PERIOD (90 Days)		
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Attending Physician 4	Date Signed (MM-DD-YYYY) 5	
Printed Name of Above Attending Physician 6		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 7	Date Signed (MM-DD-YYYY) 8	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 9		
SECOND BENEFIT PERIOD (90 Days)		
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 10	Date Signed (MM-DD-YYYY) 11	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 12		
THIRD BENEFIT PERIOD (60 Days)		
Having reviewed this patient's Medical record and/or Examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 13	Date Signed (MM-DD-YYYY) 14	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 15		
REFERRING PHYSICIAN NARRATIVE STATEMENT:		
Review of the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services. Narrative must be written legible by the physician.		
16		
SIGNATURES (Physicians must date at time of signature)		
Signature Referring Physician 17	Date Signed (MM-DD-YYYY) 18	
Printed Name of Above Physician 19		

NOTE: If additional periods are to be certified, use an additional form

VERBAL VERIFICATION (within two days of election date)		
I certify that on the date signed below a verbal verification was obtained from the physician named below; confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.		
SIGNATURES		
Physician's Name (printed) 20		
Signature of IDG Member Taking Referral 21	Printed Name of IDG Member Taking Referral 22	Date Signed (MM-DD-YYYY) 23