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 recipients. Additionally, this form may be utilized for dually eligible (Medicare/Medicaid) recipients.

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

This form along with the BHSF Form Hospice-Notice of Election (NOE) and all related documents must be electronically submitted via ePA (electronic Prior Approval) system at:

www.lamedicaid .com

Completing the BHSF Form Hospice-CTI

For Medicaid only recipients, there **must** be two different signatures on the Certification of Terminal Illness. For dually eligible (Medicare Part A) recipients, only one physician's signature is necessary.

Submission of the physician's Certification of Terminal Illness is required for the initial election period, the second 90 day period and all subsequent period. 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 10 day time limit.

Patient Information

1. Patient Name - REQUIRED
Enter the recipient's first name, middle Initial and last first name in this order.

2. 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 has applied for Medicaid and no decision has been made, the word "Pending" can be written in this field. If the patient becomes eligible for Medicaid, re-send the NOE with a line drawn through the word "Pending", and write in the 13-digit Medicaid ID number. If the original Notice of Election (NOE) and Certification of Terminal Illness (CTI) were timely sent to the Hospice Program Manager and the recipient's effective date of eligibility is on or prior to the election date, the recipient will be entitled to hospice services. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

3. Patient 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 (2^{nd}, 3^{rd}, 4^{th}, 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 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 date at time of signature.

6. Printed Name of Attending Physician Printed Name - 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 the interdisciplinary group (IDG).

8. Date Signed (MM-DD-YYYY) - REQUIRED
The Hospice Medical Director or physician member of the interdisciplinary group (IDG) must enter date at time of signature.

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 interdisciplinary group (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 interdisciplinary group (IDG).

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

The Hospice Medical Director or physician member of the interdisciplinary group (IDG) must enter date at 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 interdisciplinary group (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 interdisciplinary group (IDG).

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

The Hospice Medical Director or physician member of the interdisciplinary group (IDG) must enter date at 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 interdisciplinary group (IDG) who signed in as per number 13.

Fourth Benefit Period (60 Days)

16. 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 interdisciplinary group (IDG).

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

The Hospice Medical Director or physician member of the interdisciplinary group (IDG) must enter date at time of signature.

18. 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 interdisciplinary group (IDG) who signed in as per number 16.

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

Verbal Verification (within 2 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 recipient's prognosis of life expectancy of six months or less if the terminal illness runs its course. This verification must be obtained and submitted to the DHH Hospice Program Manager within 2 days of election date.

19. 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.

20. Signature of the IDG Member Taking Referral - REQUIRED

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

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

Print the name of the Interdisciplinary group (IDG) who signed in as per number 20.

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

The IDG member must enter date at time of signature.

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

PATIENT INFORMATION		
Patient's Name (First, Middle Initial, Last)	Patient's Medicaid ID # (13-digits)	Patient's Date of Birth (MM-DD-YYYY)

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	Date Signed (MM-DD-YYYY)
Printed Name of Above Attending Physician	
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

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)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

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)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

REFFERING PHYSICAIN 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.

SIGNATURES (Physicians must date at time of signature)

Signature Referring Physician	Date Signed (MM-DD-YYYY)
Printed Name of Above Physician	

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)**		
Signature of IDG Member Taking Referral	Printed Name of IDG Member Taking Referral	Date Signed (MM-DD-YYYY)

THIS FORM CANNOT BE ALTERED