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 dual eligible (Medicare/Medicaid) recipients.

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 recipients, there must be two different signatures on the CTI. For dual eligible (Medicare Part A) recipients, 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 recipient's first name, middle initial and last 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, electronic Medicaid eligibility verification system (e-MEVS), or the recipient eligibility verification system (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.

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 (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 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.

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 in his handwriting 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.

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.

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	

REFFERING 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