HOSPICE PROVIDER CHANGE REQUEST BETWEEN INDIANA HOSPICE PROVIDERS

State Form 48733 (R / 12-02) / OMPP 0009

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

A. PROVIDER CHANGE REQUEST EFFECTIVE DATE OF CHANGE:	☐ FIRST BENEFIT PERIOD ☐ THIRD BENEFIT PERIOD ☐ SECOND BENEFIT PERIOD

B. RECIPIENT INFORMATION	Primary hospice diagnosis (*ICD-#*):
Name of recipient (*last, first, middle initial*)	Recipient's Medicaid number
Recipient's Social Security number	

THE ABOVE NAMED RECIPIENT REQUESTS THAT THE DESIGNATION OF HIS / HER HOSPICE BE CHANGED FROM (*completed by sending hospice*):

C. PROVIDER LEAVING	
Name of Hospice Provider	Hospice Medicaid Provider number
Signature of Provider RN	Hospice telephone number
Name of Attending Physician	Physician Medicaid Provider number

TO THE FOLLOWING HOSPICE PROVIDER (*completed by receiving hospice*):

C. PROVIDER ENTERING	
Name of Hospice Provider	Hospice Medicaid Provider number
Signature of Provider RN	Hospice telephone number
Name of Attending Physician	Physician Medicaid Provider number

As a hospice recipient, I understand that this change in hospice providers is not a revocation of the remainder of my current election benefit period.

E. Signature of recipient or representative	Signature of witness	Date

NOTES:
(1) Patient must be accepted for transfer by the new provider prior to leaving current provider.
(2) Each hospice must maintain a copy of the Provider Change Request. It is the responsibility of the receiving hospice to forward a completed copy to the Medicaid Prior Authorization Unit within 5 days of the effective date stipulated in Part A above.
(3) A change of ownership is not considered a change in the patient's designation of a hospice and requires no recipient action.