MEDICAID HOSPICE PHYSICIAN CERTIFICATION

State Form 48736 (R2 / 12-02) / OMPP 0006

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

B. PROVIDER INFORMATION	
Name of hospice provider	Hospice Medicaid provider number

Please check the appropriate benefit period below:

1st hospice benefit period _____

2n hospice benefit period _____

3rd hospice benefit period _____

Should additional hospice care be required after the first 60 days of the Third Benefit Period, please complete this page again and check the appropriate box below.

THIRD BENEFIT PERIOD (*SUBSEQUENT 60 DAY PERIODS*)				
2nd 60 days	3rd 60 days	4th 60 days	5th 60 days	6th 60 days

Please specify the number of any subsequent benefit period _____

C. Having reviewed this patient's care and the course of his / her illness, I certify that this patient's medically predictable life expectancy is (6) months or less, given that the illness runs its normal course, as evidenced by the following clinical indications.

Signature of Attending Physician (*Required first hospice benefit period*)	Certification date (*month, day, year*)
Signature of Medical Director or Hospice Physician	Certification date (*month, day, year*)