Nevada Medicaid and Check Up

Nevada Medicaid Hospice Program Action Form

Upload this form through the Provider Web Portal. **For questions regarding this form, call:** (800) 525-2395

PURPOSE OF REQUEST		
☐ Discharge from Hospice Services	☐ Change of Hospice Provider	☐ Revocation of Hospice Services
Recipient Name:	Recipient Medicaid ID:	

SECTION I: DISCHARGE FROM HOSPICE SERVICES

I/Legal Representative/Agent for the recipient identified above, _____,
understand that I have been discharged from Hospice Services for the reason stated below. Initials

Date of Discharge:

Reason for Discharge:

☐ Recipient no longer meets criteria for Hospice
☐ Recipient is no longer eligible for Medicaid
☐ Recipient moved out of the Hospice service area
☐ Non-compliance with Hospice plan of care
☐ Recipient Death
Date of Death: _____

Physician's order present: ☐ Yes ☐ No

Physician's discharge clinical note present: ☐ Yes ☐ No

SECTION II: CHANGE OF HOSPICE PROVIDER

I/Legal Representative/Agent for the recipient identified above, _____,
understand that upon completion of this form I will be changing Hospice providers. I understand that I may only change the designation of the particular hospice from which hospice care will be received once in each election period. Initials

Current Hospice Provider:

New Hospice Provider:

Date of change in Hospice providers:

Reason for change:

SECTION III: REVOCATION OF HOSPICE SERVICES

I/Legal Representative/Agent for the recipient identified above, _____,
am hereby revoking hospice services. I understand that I am no longer covered for Hospice care during the remainder of this election period. I understand that I will now resume my traditional Medicaid benefits and that if at any time I elect to receive Hospice coverage for another hospice election period, I may be eligible. Initials

Date of Revocation:

Reason for Revocation:

SECTION IV: SIGNATURE

I/Legal Representative/Agent for the Medicaid recipient identified above certify that I have completed this form and understand the actions that will take place upon signature.

Recipient/Legal Representative/Agent: *(print name)*_____

Relationship to Recipient:_____

Signature:_____ Date:_____