Nevada Medicaid Hospice Program Physician Certification of Terminal Illness

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

PURPOSE OF REQUEST			
☐ Initial Certification	☐ 60 Day Certification	☐ 1st 90 Day Certification	☐ 2nd 90 Day Certification
Effective Date of Certification:			

SECTION I: PATIENT INFORMATION	
Recipient Name:	
Recipient Medicaid ID:	Date of Birth:
Parent/Legal Guardian/Agent:	Relationship to Recipient:
Hospice Provider Name:	Hospice Provider NPI:

SECTION II: PHYSICIAN EVALUATION RESULTS ***(Please note: Principal diagnoses of "debility" or "adult failure to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice care.)***

Terminal Diagnoses ICD-10 Codes:

Provide an explanation of the clinical findings supporting a life expectancy of 6 months or less if the terminal illness were to run its normal course. You may add this as an attachment if more room is needed. This physician narrative should paint a picture of the recipient's condition by illustrating the recipient's decline in detail per 42 CFR 418.22 (b)(3)(iv). Documentation should show last month's status compared to this month's status and should not merely summarize the recipient's condition for a month with generalized statements of the disease or definitions. Documentation should demonstrate why the recipient is considered to be terminal and not chronic, explaining why the recipient's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition as evidenced by current clinical data specific to the recipient, assessment findings, and other pertinent data to support this request.

SECTION III: PHYSICIAN CERTIFICATION STATEMENT

I certify that I am a physician licensed in the State of Nevada. I further certify that I entered the evaluation results listed above and that they are based on a face to face evaluation performed on *(date of certification)* _____. The conclusions listed are unbiased and free from influence. I certify that this recipient has a life expectancy of 6 months or less if the terminal illness runs its normal course.

Attending Provider:	License #:
Signature:	Date:
Hospice Medical Director:	License #:
Signature:	Date:

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Exclusion Statement I certify that the recipient identified above DOES NOT have an attending physician separate from the hospice physician.	
Hospice Medical Director:	License #:
Signature:	Date:
Hospice Representative:	Title:
Signature:	Date: