Nevada Medicaid Hospice Extended Care Physician Review Form

Purpose: Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Instructions: Submit this form with the Hospice Prior Authorization Request (form FA-95).

SECTION I: RECIPIENT INFORMATION *(to be completed by Hospice provider)*	
Recipient First Name:	Recipient Last Name:
Recipient Medicaid ID:	Recipient Date of Birth:
Hospice Provider Name:	
Hospice Provider NPI:	

SECTION II: INDEPENDENT PHYSICIAN EVALUATION RESULTS *(to be completed by the independent physician)*

Does this recipient have a terminal illness? ☐ Yes ☐ No ☐ Inconclusive

If you replied "Yes" please list the terminal diagnosis/es: (***Please note: principal diagnoses of "debility" or "adult failure to thrive" will not be accepted as meeting the eligibility criteria for Medicaid hospice.)***

Considering the normal course of the patient's diagnosis/es, does it appear the patient's life expectancy is six (6) months or less if the illness runs its normal course?

☐ Yes ☐ No ☐ Inconclusive

SECTION III: INDEPENDENT PHYSICIAN'S CERTIFICATION STATEMENT

I certify that I am a physician licensed in the state of Nevada and that I am not affiliated with the hospice agency listed in Section I above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face-to- face evaluation performed on _____(date). The conclusions listed are unbiased and free from influence.

Physician's Printed Name:	**License #:**
Physician's Signature:	**Date:**

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