

OTHER HOSPITALIZATION STATEMENT

This is to certify that hospitalization at

Name of Facility

for _____ beginning on
Recipient Name/MAID Number

_____ is not related to the terminal illness of this patient.

Date of Admission

The reason for this admission is _____ / _____
Diagnosis ICD 9 CM Code

This patient's terminal illness is _____ / _____
Diagnosis ICD 9 CM Code

Charges for this hospital stay should not be billed to the hospice agency but should be billed directly to the Kentucky Medicaid Program.

Signed: _____
Medical Director

Hospice Agency

Date

Please attach documentation verifying that hospitalization is not related to terminal illness.

Is this the first time this patient has been hospitalized for a condition not related to the terminal illness? Yes No

If no, dates of previous admission _____

Diagnosis for previous admission _____
ICD 9 CM Code

Approved by the Medicaid Program Denied by the Medicaid Program

Medicaid Signature

Date