

## KENTUCKY MEDICAID PROGRAM HOSPICE DRUG FORM

1. Recipient Last Name		2. First Name			3. Medical Assistance I.D. No.  	
4. Date Medicaid Hospice Coverage Began		5. (1) First Diagnosis (Not Related to Terminal Illness)			ICD.9 CM Code	
6. Total Number of Prescriptions Not Related to Terminal Illness		(2) Second Diagnosis (Not Related to Terminal Illness)			ICD.9 CM Code	
7. Drug Name Manufacture/Strength (10 mg, 15 ml, etc.)	8. NDC #	9. Units	10. Price Per Unit	11. Total Charge	12. Medicaid Maximum Allowance (Leave Blank)	
13. Date Span for Which These Prescriptions are Requested  _____ From _____ To _____		14. Total Units This Invoice		15. Total Charge This Invoice		16. Dispensing Fee Total
17. Terminal Diagnosis		ICD.9 CM Code		18. Did Patient Require These Prescriptions Prior to Diagnosis of Terminal Illness? _____ Yes No		
19. Are These Prescriptions the Result of Hospitalization not Related to Terminal Illness? _____ Yes _____ No			20. If Yes, Dates of Hospitalization: _____ From _____ To _____			
21. Name of Hospital			22. Prescribing Physician  _____			
23. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient.  _____						Signed
24. PROVIDER NAME AND ADDRESS		25. PROVIDER NUMBER  		26. INVOICE DATE		27. INVOICE NUMBER

**DOCUMENTATION INDICATING THAT THESE PRESCRIPTIONS ARE NOT RELATED TO THE PATIENT'S TERMINAL DIAGNOSIS MUST BE ATTACHED**