

Other Services Statement

This is to certify that the service(s) checked below provided by

_____ Name of Agency

for _____ beginning on

_____ Recipient Name/MAID Number

_____ is/are not related in any way to the terminal illness

_____ Date

of this patient.

The reason for the service(s) is _____ / _____

_____ Diagnosis ICD 9 CM Code

The patient's terminal illness is _____ / _____

_____ Diagnosis ICD 9 CM Code

Charges for this/these service(s) should not be billed to the hospice agency but should be billed directly to the Kentucky Medicaid Program.

Signed: _____

_____ Medical Director

_____ Hospice Agency

_____ Date

Durable Medical Equipment (List) _____

Hospital Outpatient Services (Please Describe Service/Reason) _____

Please attach documentation indicating service(s) is/are not related to terminal illness.

Is this the first time this patient has required services not related to terminal illness?

Yes No

If no, date(s) of previous service _____.

Previous diagnosis not related to terminal illness for which services were required

_____ ICD 9 CM Code

_____ Approved by the Medicaid Program

_____ Denied by the Medicaid Program

_____ Medicaid Signature _____ Date