



Choices for a Healthy Life

MANAGED CARE HOSPICE ELECTION/REVOCATION FORM

This form is used to inform and enable Care Management Organizations (CMOs) to authorize Hospice services provided to eligible Georgia Families members. After completing this form, fax to the appropriate Care Management Organization (CMO). Please note: Members will remain in their CMO until their category of aid is changed to Hospice.

- CHECK ONE: Amerigroup Community Care, Peach State Health Plan, Wellcare. Includes contact info for each.

SECTION I- FACILITY AND/OR MD TO COMPLETE FOR ALL HOSPICE MEMBERS

Member Information

Member Name (Last, First, MI)
Medicaid Number (MHN):
Date of Birth:(MM/DD/YYYY)
CMO ID # (if applicable):
Additional Information:

Hospice Information

Facility Name:
Phone Number:
Fax Number:
Facility Address:
City/State:
Zip Code:
Attending Physician:
Medicaid Provider Number:
Clinical Information and Diagnosis (ICD-9 Code):

SECTION II- MEMBER STATEMENT
TO BE COMPLETED BY MEMBER

- ELECTION STATEMENT:
The Georgia Medicaid Hospice Service has been explained to me. I have been given the opportunity to discuss services, benefits, requirements and limitations of this program and the terms of the election statement.
I understand that by signing the election statement I am waiving all rights to regular Medicaid services except for payment to my attending physician, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.

- ◆ I can choose to discontinue hospice care at any time. To discontinue care, I must complete a revocation statement.
- ◆ I understand that I am entitled to change the designated hospice provider one time during a benefit period.
- ◆ I understand that I am entitled to Medicaid sponsored Hospice as long as I am Medicaid eligible. The services are provided in benefit periods of initial ninety (90) day period, subsequent ninety (90) day period, and unlimited subsequent sixty day periods.

Print Name (Member/Representative): \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature (Member/Representative): \_\_\_\_\_ Date: \_\_\_\_\_  
 Hospice Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION III- REVOCATION STATEMENT**

An individual or representative may revoke the election of hospice care at any time during an election period. To revoke the election of hospice care, the individual or representative must file a revocation statement with the hospice.

**REVOCATION STATEMENT:**

- I desire to voluntarily revoke the election of hospice care.
- The Georgia Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of the program and the terms of the revocation of these services.
- I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.
- I understand I will forfeit all hospice coverage days remaining in this benefit period.
- I understand that I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.

I therefore revoke the hospice benefit because: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

Print Name (Member/Representative): \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature (Member/Representative): \_\_\_\_\_ Date: \_\_\_\_\_  
 Hospice Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION IV- CMO USE ONLY**

Date Received: \_\_\_\_\_ Approved:  YES  NO Date Effective: \_\_\_\_\_

Notification of Member Date: \_\_\_\_\_ Notification of Provider Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_