PHYSICIAN'S CERTIFICATION FOR MEDICAID HOSPICE BENEFIT

Physician Certification of Terminal Illness
for Hospice Medicaid Benefit

A. Certification Statement for First 90-Day Period

I (or we) certify that _____, is terminally ill with a life expectancy of six months or less. (Patient's name)

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

_____ _____
(Date by Physician) (Attending Physician Signature)

B. Recertification Statement Second 90-Day Period

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

C. Recertification Statement for 60-Day Period

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

D. Recertification Statement for 60 day Period

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)