State of Illinois
Department of Healthcare and Family Services

# Notification to HFS of Illinois Medicaid Hospice Benefit Election

The Illinois Department of Healthcare and Family Services (HFS) requires certain information from hospice agencies in order to authorize and pay for hospice care services provided to eligible participants. Completion of this form is mandatory. If a participant is covered under a managed care entity (MCE) contracted with HFS, hospice providers must also submit a copy of this form to the MCE. This form must be completed in its entirety or it will be returned to the provider for completion.

**Section 1 - Complete for All Hospice Patients**

The participant named on this form has elected to receive the Medicaid hospice benefit. The participant signed a notice of election form on the date identified below and has been certified by a physician as having six months or less of life expectancy if the illness follows its usual course. The notice of election form signed by the participant, and the physician certification of terminal illness statement, must comply with the requirements in Section 4305 of the *State Medicaid Manual* (published by the federal Centers for Medicare and Medicaid Services) and HFS administrative rules at *89 Illinois Administrative Code Section 140.469* and are to be retained by the hospice in the patient file. Election statements for children through age 20 differ in that they must inform pediatric patients that they are entitled to all Medicaid benefits concurrently with hospice care.

| Name - Participant (last, first, MI) | Participant's Recipient Identification Number | Date Election for Medicaid Hospice Benefit Was Signed |
|---|---|---|
| | | |
| Name - Hospice | Hospice's Medicaid Provider Number | Hospice's NPI |
| | | |

## Section II - Complete for Discharge of Participant from Hospice Care

Complete this section only if one of the following conditions applies:

- The participant revoked hospice care;
- The participant no longer meets the criteria for hospice care;
- The participant was discharged for cause;
- The participant transferred to another hospice;
- The participant expired.

The revocation or transfer statement signed by the participant is to be retained by the hospice in the patient file.

Specify Reason for Non-continuance of Hospice Care: Revocation, Participant No Longer Meets Criteria, Discharge for Cause, Transfer, or Death:

______________________________________________

Date of Death or Non-continuance of Hospice Care: ______________________

## Section III - Notification of Election Submission Instructions

When complete, mail or fax this form to:

Attention: UB Billing Unit
Illinois Department of Healthcare and Family Services
Bureau of Hospital and Provider Services
P. O. Box 19128
Springfield, Illinois 62794-9128

The telefax number is 217-524-4283, Attention: UB Billing Unit

Hospice Representative Signature ______________________ Date: ______________

**For HFS Staff Use Only:**

| Date Received from Hospice: | Date Entered into System: | Staff Name: |
|---|---|---|