MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

EFFECTIVE CHANGE DATE:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

APPLICABLE BENEFIT PERIOD:

_____FIRST 90 DAYS _____SECOND 90 DAYS _____PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME: LAST FIRST	SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:	MEDICARE NUMBER:

RELEASING HOSPICE PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed from:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The sending hospice must complete the above section. A copy of this form must be sent to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date and be forwarded to the receiving hospice within two (2) days of the effective date.

RECEIVING PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The receiving hospice must forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date.

SIGNATURES:

As a recipient of hospice services, I understand that I may change hospice providers only ONCE during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election benefit period.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
SIGNATURE OF WITNESS	DATE OF SIGNATURE

DHHS FORM 152 (10/95) (REVISED 12/08) Each hospice must maintain a copy of this Provider Change Request Form. It is the responsibility of the receiving hospice to forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date of the change.