MEDICAID HOSPICE DISCHARGE

State Form 48734 (R / 12-02) / OMPP 0008

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

A. RECIPIENT INFORMATION	Primary hospice diagnosis (*ICD-#*):
Name of recipient (*last, first, middle initial*)	Recipient's Medicaid number
Recipient's Social Security number	

B. HOSPICE PROVIDER INFORMATION	
Name of Hospice Provider	Hospice Provider number

C. DISCHARGE STATEMENT

Hospice benefits for the above named recipient, enrolled with the above named provider since _____ / _____ / _____ have terminated on _____ / _____ /_____ for the following reasons:

- ☐ Recipient is deceased. Date of death was _____ / _____ / _____ .
- ☐ Prognosis is now greater than six months.
- ☐ Safety of recipient or hospice staff is compromised (*explain below and attach revelent documentaion*).
- ☐ Recipient moved out of service area.
- ☐ Other (*explain below*)

Signature of Medical Director or Patient Care Coordinator	Date