magnolia health

MAGNOLIA HEALTH PLAN HOSPICE PHYSICIAN CERTIFICATION/RECERTIFICATION

RECIPIENT INFORMATION:

NAME: LAST FIRST		MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET		SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:
HOME PHONE NUMBER (INCLUDE AREA CODE):	BIRTH DATE:	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE:	MEDICAID PROVIDER NUMBER OF NURSING FACILITY:	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:	ICD-9-CM NUMBER INDICATIING THE PRIMARY HOSPICE DIAGNOSIS:	
NAME HOSPICE:_____ ADDRESS:	NPI NUMBER:	
COUNTY WHERE SERVICES RENDERED	MEDICAID PROVIDER NUMBER:	

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR

_____ **First BENEFIT PERIOD (90 DAYS): From** _____ **Thru** _____

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

Print name _____ _____ SIGNATURE OF ATTENDING PHYSICIAN NPI #	CERTIFICATION DATE:
Print name _____ _____ SIGNATURE OF HOSPICE MEDICAL DIRECTOR NPI #	CERTIFICATION DATE:

_____ **Second BENEFIT PERIOD (90 DAYS): From** _____ **Thru** _____

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.

Print name _____ _____ SIGNATURE OF HOSPICE MEDICAL DIRECTOR NPI #	CERTIFICATION DATE:

_____ **BENEFIT PERIOD (60 DAYS) From** _____ **Thru** _____

Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case. (ATTACH FACE TO FACE ENCOUNTER FOR THIS & SUBSEQUENT PERIODS)

Print name _____ _____ SIGNATURE OF HOSPICE MEDICAL DIRECTOR NPI #	CERTIFICATION DATE:

Magnolia Health
www.magnoliahealthplan.com
Questions: Phone Toll Free 1-866-912-6285
Fax: 1-877-650-6943