

**Nevada Medicaid 60-Day Physician Re-Certification of Terminal Illness
Hospice Care**

Section 1 -Patient Information:	
Patient's Name:	
DOB	Medicaid ID #:
Parent/Legal Guardian: Relationship to Patient:	
Hospice Provider:	

Section 2 - Physician evaluation results:
<i>Please note: Principal diagnoses of 'debility' or 'adult failure to thrive' will not be accepted as meeting the eligibility criteria for Medicaid hospice care.</i>
List terminal diagnoses:
Brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less:

Section 3 – Physicians Certification Statement:
<i>I certify that I am a physician licensed in the state of Nevada. I further certify that I entered the evaluation results listed above and that they are based on a face to face evaluation performed on _____ . The conclusions listed are unbiased and free from influence.</i> <i>Date</i>

Attending Physician's name: _____ License #: _____

Signature: _____ Date: _____

Hospice Medical Director's name: _____ License #: _____

Signature: _____ Date: _____

Exclusion Statement

I certify that the recipient identified above DOES NOT have an attending physician separate from the hospice physician.

Hospice Medical Director: _____

Signature: _____ Date: _____

Hospice Physician: _____ License #: _____

Signature: _____ Date: _____