

Nevada Medicaid 90 Day Physician Re-Certification of Terminal Illness

Adult Hospice Care

Section 1 -Patient Information:

Patient's Name: _____

DOB: _____

Medicaid ID #: _____

Hospice Provider: _____

Section 2 - Physician evaluation results:

Please note: Principal diagnoses of 'debility' or 'adult failure to thrive' will not be accepted as meeting the eligibility criteria for Medicaid hospice care.

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 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.* *Date*

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: _____