Hospice Enrollment /Disenrollment Authorization Request

Facsimile Sheet

TO:	FROM:
Administrative Office Specialist Division of Long-Term Care Department of Medical Assistance Services 600 East Broad Street, 10th Floor Richmond, Virginia 23219	Contact Person: ____________________ Phone Number: ____________________ Fax Number: ____________________
Fax: (804) 452-5456 OR Fax: (804) 452-5468	Provider Name: ____________________ Provider NPI Number: ____________________

Please complete all the following information for each Hospice enrollment. Incomplete forms will not be processed. One individual and one enrollment per form. Fax this form to either of the fax numbers listed above. Please print legibly. (**NOTE**: Do not submit any other paperwork with this form)

1. Individual Name: ______________________________
2. Individual Medicaid Number: ______________________________
   (Required- Do Not submit this enrollment if you do not have an active Medicaid number for the individual)
3. Date individual/representative signed hospice election: ____________________
4. Date Attending Physician signed DMAS 420: ____________________
   (*If individual is re-electing their hospice benefit, attending physician does not need to sign DMAS 420)*
5. Date Hospice Medical Director signed DMAS 420: ____________________
6. Change in hospice providers? ______Yes ______No
7. Date of hospice disenrollment/revocation/termination: ____________________
8. Reason for disenrollment/revocation/termination: ____________________

CONFIDENTIAL-CONTAINS PATIENT IDENTIFIABLE INFORMATION

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