DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01010 (08/2019)

STATE OF WISCONSIN
DHS 107.31(2)(b), Wis. Admin. Code

WISCONSIN MEDICAID

HOSPICE BENEFIT REVOCATION (NON-RECERTIFICATION) / VOLUNTARY DISCHARGE

ForwardHealth requires certain information to enable the program to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number, Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

Provision of the information requested on this form is mandatory; however, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Hospice benefits are covered services for members enrolled in Wisconsin Medicaid or BadgerCare Plus.

Instructions: Type or print clearly. Keep this information in the member's records; *do not* send it to ForwardHealth.

Name — Member	Name — Hospice

I, the member, (check one):

- ❑ Understand that my attending physician and the Hospice Interdisciplinary Team have determined that at this time I do not meet the Medicaid criteria for the hospice benefit. The basis for this has been explained to me.
- ❑ Choose to revoke election for Medicaid coverage for hospice care provided by the hospice program named above.

Hospice coverage will continue through _____ (MM/DD/YY). Medicaid hospice reimbursement will continue through _____ (MM/DD/YY).

I understand that my Medicaid hospice benefits will cease. If it is determined that I once again meet the Medicaid criteria for the hospice benefit, I may re-elect Medicaid hospice coverage.

I understand that the Medicaid health care benefits I waived to receive Medicaid hospice coverage will resume on _____ (MM/DD/YY, the day following the last day of hospice coverage).

❑ *I agree* / ❑ *I do not agree* (check one) to waive the 14-day waiting period required by the State of Wisconsin for voluntary discharge from the hospice named above.

SIGNATURE — Member or Legal Representative	Date Signed
SIGNATURE — Hospice Representative	Date Signed

Reset Form