

**WISCONSIN MEDICAID
PHYSICIAN CERTIFICATION / RECERTIFICATION OF TERMINAL ILLNESS**

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.

SECTION I — CERTIFICATION STATEMENT

Name — Member

Member ID

Description of Disease

We (or I) certify that the above-named Medicaid member is terminally ill with the disease described above. His or her life expectancy is six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee

Certification Date

SIGNATURE — Attending Physician

Certification Date

National Provider Identifier

Date Signed

SECTION II — RECERTIFICATION STATEMENT

I recertify that the above patient is still considered terminally ill with the above-stated disease and has a life expectancy of six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee

Recertification Date

Date Signed
