Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Hospice Bulletin 8
September 2008

To: Hospice Providers Participating in MassHealth

From: Tom Dehner, Medicaid Director

RE: **Changes to the MassHealth Hospice Form**

Background

MassHealth requires hospice providers to complete the MassHealth Hospice Form when a MassHealth member seeks to elect or revoke hospice services, to disenroll from hospice services, or to change hospice providers. The MassHealth Hospice Form has been slightly modified to support the future implementation of NewMMIS.

Changes in the MassHealth Hospice Form

Most of the content of the MassHealth Hospice Form remains the same. The most significant change to the form is in the section completed when a member discontinues hospice services. The MassHealth Hospice Form has been revised to include disenrollment reasons. Hospice providers must now identify a disenrollment reason when a member discontinues hospice services for any reason, other than when a member decides to stop using hospice services (revocation).

The disenrollment reasons include an option of "Other." If the provider indicates "Other," the provider must explain the reason for disenrollment on the form. The member or a representative must sign and date the MassHealth Hospice Form where required, and hospice program staff must sign and provide the effective date of hospice disenrollment.

Hospice providers must use this revised form beginning October 1, 2008.

Change in Mailing Address

Hospice providers must mail the MassHealth Hospice form to the following address.

Hospice Unit
UMMS-CHCF
529 Main Street
Charlestown, MA 02129

Providers can also fax the form to 617-886-8133 or 617-886-3132.

(continued on next page)

Supplies of Forms

Attached to this bulletin is a sample of the MassHealth Hospice Form.

You can download the form from the MassHealth Web site. On the home page of www.mass.gov/masshealth, click on MassHealth Provider Forms in the Publications panel on the right side of the page.

To order the form online, click on Order Provider Publications under Online Services.

To request copies of the form, send your request to the following address.

MassHealth Forms Distribution
P.O. Box 9118
Hingham, MA 02043

Fax: 617-988-8973

Note: Be sure to include your provider number and the exact title of the form.

Questions

If you have questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Hospice Form

Instructions

This form must be completed whenever a MassHealth member chooses to elect or stop hospice services, to disenroll from hospice services, or to change hospice provider. MassHealth does not pay for hospice services unless a completed MassHealth Hospice Form has been submitted, and will not pay for hospice services provided before the effective date entered on the form. The effective date for hospice services may not be earlier than the date the member or the member's representative signs the form.

The hospice provider must complete Section A below and then complete either Section B (Hospice Election), Section C (Hospice Revocation), or Section E (Hospice Change) with the member or the member's representative. The hospice provider may complete Section D (Hospice Disenrollment) without the signature of the member or the member's representative.

Fax the completed form to 617-886-8133 or 617-886-3132 or mail the form to:

Hospice Unit
UMMS-CHCF
529 Main Street
Charlestown, MA 02129

Section A: Hospice Provider and Member Information *(Required)*

MassHealth Provider Number/NPI: ______________________________

Hospice Provider Name, Address, and Phone No.: ______________________________

____

____

MassHealth Member ID: ______________________________

MassHealth Member Name and Address: ______________________________

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____

Member Diagnosis: ______________________________

____

Section B: Hospice Election *(Complete this section when the member chooses hospice services.)*

For MassHealth MCO Members Only: MassHealth MCO members can elect hospice services through their MCO. MCO members who elect hospice services by signing this form will be automatically disenrolled from their MCO.

Effective date of hospice election: ___/___/___

Member Statement

I agree to get all care for my terminal illness from the hospice provider named above. I know that hospice services are for my care and comfort, and not for curing me. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice provider.

______________________________ ___/___/___
Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

☐ Member: ______________________________
☐ Member's representative: ______________________________

Section C: Hospice Revocation *(Complete this section when the member decides to stop hospice services.)*

Effective date of hospice revocation: ___/___/___

Member Statement

I want to stop receiving hospice services and begin receiving MassHealth benefits from any MassHealth provider. I know that by signing this form, MassHealth will not pay for hospice services for me as of the revocation date. I can still get hospice coverage later if I sign up again.

____ ___/___/___

Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

☐ Member: ____

☐ Member's representative: ____

Section D: Hospice Disenrollment *(Complete this section to disenroll the member from hospice.)*

Effective date of hospice disenrollment: ___/___/___

Select reason for disenrollment:

☐ Death *(The member has died.)*

☐ Loss of eligibility *(The member is no longer in a MassHealth benefit plan that covers hospice services, or the member is not eligible for MassHealth.)*

☐ Health-care needs changed *(The member's health condition has improved and the six-month prognosis has changed.)*

☐ Enrolled in all-inclusive managed care plan *(The member's health-care needs will be managed by the plan.)*

☐ Other *(If the reason is none of the above, explain the reason in detail.)*

____

____

____

Signature of Hospice Provider Staff Person Completing the Form

Section E: Hospice Change *(Complete this section when the member is changing hospice providers.)*

A **newly designated hospice provider** must complete Section A and this section, including getting a date and signature from the member or the member's representative, and submit the completed form to MassHealth at the address appearing above.

Effective date of hospice discharge from previous hospice provider: ___/___/___

Effective date for the newly designated hospice provider: ___/___/___

Member Statement

I want to change to a different hospice provider.

The hospice provider I have now is: ____

The hospice provider I want to change to is: ____

____ ___/___/___

Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

☐ Member: ____

☐ Member's representative: ____