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

MassHealth Hospice Election Form

Hospice providers must submit the MassHealth Hospice Election Form either electronically through the MassHealth LTSS Provider Portal, or by sending this paper form to the MassHealth Hospice Unit for Fee-for-Service (FFS) MassHealth members, and MassHealth members enrolled in the Primary Clinician Plan (PCC Plan) or a Primary Care ACO Plan under the following circumstances:

- A MassHealth member, including a dual-eligible member elects hospice services, revokes hospice services, or changes their hospice provider; or
- A hospice provider disenrolls a member from hospice services.

IMPORTANT: MassHealth does not pay for hospice services unless a completed MassHealth Hospice Election Form has been submitted, and MassHealth does 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 that the member or the member's representative signs the form.

ATTENTION

- For MassHealth members who are enrolled in a Managed Care or Integrated Care Plan (collectively "Health Plans"), the hospice provider must coordinate with the MassHealth member and the member's Health Plan for the member to elect the MassHealth hospice benefit. Submission of this form for a member enrolled in a Health Plan may cause the member to be unintentionally disenrolled from the Health Plan.
- All MassHealth members who also have Medicare coverage ("dual-eligible members") must simultaneously elect and revoke the MassHealth and Medicare hospice benefits. For dual-eligible members who are enrolled in an Integrated Care Plan (One Care, PACE, or SCO), the hospice provider must coordinate with the MassHealth member and the member's plan for the member to elect the MassHealth and Medicare hospice benefits.

Directions for completing form (Complete the signature section ONLY for the section that pertains to your election.)

For members electing hospice
- Complete Sections A, B, C, and D.

For members changing hospice providers
- Complete Sections A, B, C, and E.
- It is the responsibility of the newly designated hospice provider to complete this section.

For members revoking their election of hospice
- Complete Sections A, B, C, and F.

For members disenrolling or being disenrolled
- Complete Sections A, B, C, and G.

For individuals seeking MassHealth eligibility
- Complete Sections A, B, C, and H.
- The hospice provider must submit this hospice election form to MassHealth upon MassHealth's approval of the member's coverage type that includes hospice services.

Submission Instructions

Hospice providers may submit this form electronically through the MassHealth LTSS Provider Portal at: www.masshealthltss.com.

Alternatively, hospice providers may submit the completed form by

Fax: (855) 656–3381 or Mail:
MassHealth LTSS-Hospice Enrollment Unit
PO Box 159108
Boston, MA 02215

Contact the MassHealth LTSS Provider Service Center at (844) 368-5184 if you have questions about this form.

Section A: Provider Information (Required)

MassHealth Hospice Provider Number	Hospice Phone Number	Provider NPI Number

Name of Hospice Provider	Hospice Provider Address

Name of Nursing Facility (if applicable)	Nursing Facility NPI Number (if applicable)

Address of Nursing Facility (if applicable)

Section B: Member Information (Required)

MassHealth Member Number

Member Name (last, first, middle initial)	Member Telephone Number

Member Address (number and street, apartment number, city, state, ZIP code)

Member Date of Birth

_____ / _____ / _____

Pediatric Patient (under age 21)

☐ Yes ☐ No

The MassHealth hospice effective date may not be earlier than the date that the member or the member's representative signs the election form.

Hospice Admit Date	MassHealth Hospice Effective Date	Hospice Diagnostic Code (ICD-10)
_____ / _____ / _____	_____ / _____ / _____	

Attending Physician Name (if applicable)	Attending Physician Phone Number (if applicable)

Section C: MassHealth, Medicare, and Other Insurance Information (Required)

Member is MassHealth enrolled at time of hospice admission ☐ Yes ☐ No

If no, see Section H: Individuals Seeking MassHealth Eligibility

Member also has Medicare ☐ Yes ☐ No If Yes, Member Medicare Beneficiary ID Number	Medicare Hospice Election Date (if applicable) _____ / _____ / _____

Other Insurance Information

Member is covered under another insurance with a hospice benefit (if known) ☐ Yes ☐ No

Insurer Name (if applicable)	Policy Number (if applicable)

Section D: Election Statement (as applicable)

a) I acknowledge that I have been given a full explanation and understand the purpose of hospice care. Hospice care is intended to relieve pain and other symptoms related to my terminal illness and related conditions, and is not intended to be curative. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

b) I agree to receive all hospice services from the hospice provider named below. I understand that unless I sign a form to stop hospice services or change hospice providers, I must continue to receive all hospice services from the hospice provider named below.

c) For members age 21 and over: I understand that by electing hospice care under the MassHealth hospice benefit, I waive all rights to MassHealth benefits for any MassHealth services that are related to the treatment of my terminal illness and related conditions (excluding room and board in a nursing facility). I understand that while this election is in force, MassHealth will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.

d) I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by MassHealth.

e) I understand that if I have both MassHealth and Medicare, I must elect the MassHealth hospice benefit and the Medicare hospice benefit simultaneously.

I acknowledge and understand the above, and elect to receive MassHealth hospice services from

_____ to begin on _____

(Hospice Provider) (Effective Date of Election)

! Important: The effective date of the election may not be earlier than the date the member or the member's representative signs this form.

Note: MassHealth members under age 21 who elect hospice services do not waive the right to MassHealth coverage for services that are related to the treatment of their terminal illness and related conditions.

_____ _____ / _____ / _____

Signature of ☐ MassHealth Member ☐ Legal Guardian/Authorized Representative Date of Signature

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Name of Legal Guardian/Authorized Representative (if applicable)	Legal Guardian/Representative's Relationship to Member

Section E: Change of Hospice Provider (as applicable)

Newly Designated MassHealth Hospice Provider	Newly Designated MassHealth Hospice Provider Number
Newly Designated MassHealth Hospice Provider NPI Number	
Member Name (last, first, middle initial)	Member Date of Birth _____ / _____ / _____
MassHealth Member Number	Name of Current Hospice Provider
Effective date of hospice discharge from previous hospice provider _____ / _____ / _____	
Effective date of election to newly designated hospice provider _____ / _____ / _____	Note: The effective date of election to newly designated hospice provider may not be the same date as the discharge from previous hospice provider.

☐ I want to change to a different hospice provider.

_____ _____ / _____ / _____

Signature of ☐ MassHealth Member ☐ Legal Guardian/Authorized Representative Date of Signature

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Name of Legal Guardian/Authorized Representative (if applicable)	Legal Guardian/Representative's relationship to member

Section F: Revocation of Election of Hospice (as applicable)

MassHealth Hospice Provider Number	Provider NPI Number	
Member Name (last, first, middle initial)	Member Date of Birth _____ / _____ / _____	
MassHealth Member Number	Revocation Effective Date _____ / _____ / _____	
Member also has Medicare ☐ Yes ☐ No If yes, Medicare Revocation of Hospice Election Effective Date _____ / _____ / _____		

I choose to revoke my election of the MassHealth hospice benefit and acknowledge the following.

a) I will no longer receive MassHealth hospice services unless I execute a new election form. I may execute a new election form at any time, provided that I qualify for hospice services.

b) By revoking my election of the MassHealth hospice benefit, I no longer waive the right to receive other MassHealth-covered services.

In addition to the above acknowledgement, I understand that if I have both MassHealth and Medicare, I must revoke the MassHealth hospice benefit and the Medicare hospice benefit simultaneously.

_____ _____ / _____ / _____

Signature of ☐ MassHealth Member ☐ Legal Guardian/Authorized Representative Date of Signature

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Name of Legal Guardian/Authorized Representative (if applicable)	Legal Guardian/Representative's relationship to member

Section G: Hospice Disenrollment (as applicable)

MassHealth Hospice Provider Number	Provider NPI Number	
Member Name (last, first, middle initial)	Member Date of Birth _____ / _____ / _____	
MassHealth Member Number	Disenrollment Effective Date _____ / _____ / _____	

Type of Discharge (Please check one of the following boxes)

☐ Member is no longer terminally ill. (Member's health condition is improved, and six-month prognosis has changed.)

☐ Member has chosen to receive care in an inpatient facility that the hospice provider does not contract with.

☐ Member is enrolled in a managed care plan that will manage the member's healthcare needs. (See Attention paragraph on page 1 of election form for clarification.)

☐ Member moved out of the hospice provider's service area.

☐ Discharge for cause in accordance with 42 CFR 418.26(a)(3) because the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that it seriously impairs the delivery of care to the patient or the ability of the hospice to operate effectively. By checking this box, the hospice provider certifies that it

a) Has advised the patient that a discharge for cause is being considered.

b) Made a serious effort to resolve the problem(s) presented by the patient's behavior or situation;

c) Ascertained that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and

d) Documented the problem(s) and efforts made to resolve the problem(s) and entered this documentation into its medical records.

☐ Other (explain in detail)

_____ _____ / _____ / _____

Signature of Hospice Provider Staff Person Completing the Form Date of Signature

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

_____

Printed Name of Hospice Provider Staff Person Completing the Form

Section H: Individuals Seeking MassHealth Eligibility (as applicable)

This section must be completed, as applicable, for the following two scenarios. Completion of this section permits MassHealth coverage of an individual's hospice services to begin no earlier than the date of the signature of the individual or individual's representative below and in accordance with the effective date of the individual's MassHealth coverage.

Individual meets criteria below at time of hospice admission ☐ Yes ☐ No

1. Individual attests that they or their legal representative have submitted the Massachusetts Application for Health and Dental Coverage and Help Paying Costs (ACA-3) or the Application for Health Coverage for Seniors and People Needing Long-Term-Care Services (SACA-2) which is pending for MassHealth eligibility. Date application was submitted to MassHealth (if known)

   _____ / _____ / _____

Or

2. Individual is not currently enrolled in MassHealth but may apply for MassHealth coverage at a future date.

If yes, please review the following election statement with the individual and/or the individual's representative.

Election Statement

a) I acknowledge that I have been given a full explanation and understand the purpose of hospice care. Hospice care is intended to relieve pain and other symptoms related to my terminal illness and related conditions, and is not intended to be curative. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

b) I acknowledge that if I become enrolled in a MassHealth coverage type that includes hospice services, I agree to receive all hospice services from the hospice provider named below. I understand that unless I sign a form to stop hospice services or change hospice providers, I must continue to receive all hospice services from the hospice provider named below.

c) For individuals age 21 and over: I acknowledge that if I become enrolled in a MassHealth coverage type that includes hospice services, I understand that by electing hospice care under the MassHealth hospice benefit, I waive all rights to MassHealth benefits for any MassHealth services that are related to the treatment of my terminal illness and related conditions (excluding room and board in a nursing facility). I understand that while this election is in force, MassHealth will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.

d) I understand that if I become enrolled in a MassHealth coverage type that includes hospice services, services that are not related to my terminal illness or related conditions will continue to be eligible for coverage by MassHealth.

e) I understand that if I become enrolled in a MassHealth coverage type that includes hospice services and I have Medicare, I must elect the MassHealth hospice benefit and the Medicare hospice benefit simultaneously.

I acknowledge and understand the above, and if I become enrolled in a MassHealth coverage type that includes hospice services, I elect to receive MassHealth hospice services from

_____ to begin on _____

(Hospice Provider) (Effective Date of Election)

Important: The effective date of the election may not be earlier than the date the individual or the individual's representative signs this form.

Note: MassHealth members under age 21 who elect hospice services do not waive the right to MassHealth coverage for services that are related to the treatment of their terminal illness and related conditions.

_____ _____ / _____ / _____

Signature of ☐ Individual ☐ Legal Guardian/Authorized Representative Date of Signature

The form can either be signed by hand and then scanned, or it can be signed electronically using a digital signature tool, such as DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Name of Legal Guardian/Authorized Representative (if applicable)	Legal Guardian/Representative's relationship to individual

Print **Clear**