This form must be completed and submitted to the MassHealth Hospice Unit when
• A MassHealth member or MassHealth applicant elects hospice services, revoke hospice services, or changes her or his 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, except for those who have pending MassHealth enrollment applications.

ATTENTION
• MassHealth members who are enrolled in an Accountable Care Partnership Plan (ACPP) or a Managed Care Organization (MCO) are eligible to access the hospice benefit through their ACPP or MCO provider network. ACPP and MCO members who elect to receive the MassHealth hospice benefit by filling out this form will be disenrolled from the ACPP or MCO in accordance with 130 CMR 508.002(a)(7).
• MassHealth Senior Care Options (SCO), Program of All-Inclusive Care for the Elderly (PACE), and One Care members can elect hospice services through their SCO, PACE, or One Care program. If a SCO, PACE, or One Care member wants to receive hospice services through an out-of-network provider, the member and the out-of-network provider should work with the member’s SCO, PACE, or One Care program to initiate hospice services.

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, C1, C2, and D.

For members changing hospice providers
• Complete Sections A, B, C1, C2, 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, C1, C2, and F.

For members disenrolling or being disenrolled
• Complete Sections A, B, C1, C2, and G.

For those who have an eligibility application pending with MassHealth
• Complete Sections A, B, C1, and C2.
• Section D must also be completed if and when the individual’s MassHealth eligibility is approved.
• If the individual dies prior to MassHealth eligibility approval, completion of Sections A, B, C1, and C2 will be sufficient and Section D will not be required.
• 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.

Fax the completed form to (855) 656-3381 or mail the form to
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)**

<table>
<thead>
<tr>
<th>MassHealth Hospice Provider Number</th>
<th>Hospice Phone Number</th>
<th>Provider NPI Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Hospice Provider</th>
<th>Hospice Provider Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Nursing Facility (if applicable)</th>
<th>Nursing Facility NPI Number (if applicable)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address of Nursing Facility (if applicable)</th>
</tr>
</thead>
</table>

**Section B: Member Information (Required)**

<table>
<thead>
<tr>
<th>MassHealth Member Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Name (last, first, middle initial)</th>
<th>Member Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Address (number &amp; street, apt. number, city, state, ZIP)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Date of Birth</th>
<th>Pediatric Patient (under age 21)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospice Admit Date</th>
<th>MassHealth Hospice Effective Date</th>
<th>Hospice Diagnosis Code (ICD-10)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Attending Physician Name (if applicable)</th>
<th>Attending Physician Phone Number (if applicable)</th>
</tr>
</thead>
</table>

**Section C1: MassHealth Insurance Information (Required)**

Member is MassHealth-enrolled at time of hospice admission | YES | NO

If no, applicant 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 Service (SACA-2) which is pending for MassHealth eligibility. Date application was submitted to MassHealth (if known) | / | / |

Signature of | Applicant with pending MassHealth eligibility status | Legal Guardian/Authorized Representative | Date of Signature

Name of Legal Guardian/Authorized Representative (if applicable) | Legal Guardian/ Representative’s relationship to applicant

**Section C2: Medicare/Other Insurance Information (Required)**

Member also has Medicare | YES | NO

If Yes, Member Medicare Beneficiary ID Number

If member has Medicare, member has elected the hospice benefit under Medicare | YES | NO

Medicare Hospice Election Date (if applicable) | / | / |

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

(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

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 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

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 ____ /____ /_______

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.

Signature of [ ] MassHealth Member [ ] Legal Guardian/Authorized Representative

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

Date of Signature

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

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

da) 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

Printed Name of Hospice Provider Staff Person Completing the Form