Washington State Department of Social & Health Services

MAA Medical Assistance Administration

MEDICAID HOSPICE 5-DAY NOTIFICATION

MAA Hospice Program Manager
Division of Medical Management
(360) 725-1582 or (360) 725-1570 FAX: (360) 725-1965

Please fill out the form electronically to ensure the form can be read easily then print the form.

1. Hospice Provider Number 399 _____ (7 digits)

Name and address of Hospice Agency:
Please send award letter to this address

2. HOSPICE CONTACT NAME

3. TELEPHONE NUMBER

4. FAX NUMBER

5. E-MAIL (Do not use client identifiers in e-mail)

6. ☐ Election Actual Date

7. ☐ **Change of Status** Date _____
Check One: ☐ Expired ☐ Discharge
☐ Revoke ☐ Transfer
Reason for DC or revoke/change

8. PHYSICIAN CHANGE DATE

9. NEW PHYSICIAN NAME

10. NEW PHYSICIAN PROVIDER NUMBER

11. CLIENT PIC NUMBER

12. SOCIAL SECURITY NUMBER (TYPE NUMBERS ONLY)

13. DIAGNOSIS

14. ☐ Assessment sent to MAA (when required for Medicaid only clients)

15. PHYSICIAN NAME

16. PHYSICIAN MAA PROVIDER NUMBER (7 digits)

17. Medicare Eligible? ☐ Yes ☐ No

☐ Medicare Primary at home (Dual eligible but not accessing the Medicaid hospice benefit)

Start Date: _____

☐ Part A & B

☐ Part B only

☐ Part A only

☐ Dual eligible client in the nursing home has elected Medicare Hospice benefit/Medicaid room and board.

18. CLIENT NAME: LAST FIRST MI

19. HCS OR CSO CONTACT NAME

20. TELEPHONE NUMBER

21. FAX NUMBER

22. CLIENT DSHS ID NUMBER

23. CLIENT DATE OF BIRTH

24. ☐ LATE NOTIFICATION, GIVE REASON

25. DATE OF ELIGIBILITY LETTER

26. ☐ Award letter faxed to Hospice

27. RESIDENCE - CHECK WHERE CLIENT LIVES.
(If more than one. list the dates).

☐ Home (includes Adult Family or Boarding Home and Assisted Living Facility)

☐ Nursing Home

Name _____

☐ Hospice Care Center (145)

Name _____

☐ In-Patient Hospital (656)

28. MEDICAID HOSPICE START DATE (DSHS uses only)

MAA USE ONLY

CNP LCP/MNP PCOP
MMIS
Database
Letter to agency
☐ **Assessment Reviewed by MAA**

29. NOTES

DSHS 13-746 (REV. 06/2005)

Important Notice: This message is intended for the use of the person or entity to which it is addressed and may contain confidential information and is exempt from disclosure under applicable law. Dissemination, distribution or copying of this information is strictly prohibited. If you have received this in error, please **notify** us immediately **and destroy** this message.

INSTRUCTIONS FOR HOSPICE AGENCIES COMPLETING THE MEDICAID HOSPICE 5-DAY NOTIFICATION

Please fill out the form electronically to ensure the form can be read easily then print the form.

1. Enter the last 4 digits of your MAA Provider number. The first 3 are already on the form. Enter your Hospice agency name and complete address. (The HCS or CSO will need your address in order to send an Award Letter to your agency.)
2. Enter the first and last name of the Hospice contact person.
3. Enter the telephone number for the Hospice contact person.
4. Enter the fax number for the Hospice contact person.
5. E-mail address is optional. (Use e-mail only for non-client specific information.)
6. Mark the box if this is an election and enter the actual date the client elected Hospice.
7. If there is a change of circumstances, please use the original fax and add the date of the change after marking the change box. Circle or underline the type of change and give the client specific reason for discharges or revokes: Example, client left the area; client wanted chemotherapy that was not part of the POC.
8. If the client's physician has changed, enter the date changed to the new physician.
9. Enter the name of the new physician.
10. Enter the new physician's 7 digit provider number.
11. Enter the client Patient Identification Code (PIC) which is the insured's ID number for Medicaid which has the client's first and middle initial, ("-" if no middle name) 6 digit birthday; first 5 letters of the last name (leave a space for each letter short of 5); and an alpha or numeric character for the tiebreaker. If no PIC, leave empty. Client must have a PIC in order for MAA to accept the 5-Day Notice.
12. Enter the client's Social Security Number (SSN) using numbers only. This along with the PIC can help in identifying the client.
13. Enter the name for the primary diagnosis.
14. Mark if assessment is attached. You only need to fax for clients who are Medicaid **only** and do not have a cancer diagnosis.
15. Enter the attending Physician's name.
16. Enter the attending Physician's Provider number.
17. Enter if the client is Medicare eligible or not. Mark the boxes that apply. Leave blank if unknown.
18. Enter the client's last name, first name and middle initial (add "-" if the client does not have a middle initial).
19. Enter the name of the client's Home and Community Services Office (HCS) or Community Services Office (CSO) and the contact name if known.
20. Enter the HCS or CSO telephone number.
21. Enter the HCS or CSO fax number.
22. Enter the client ID from the HCS or CSO if known (begins with 00_____). Leave blank if you do not know, it is on the bottom of the Award Letter.
23. Enter the client's date of birth (this can help us in finding the client if another identifier is placed incorrectly).
24. If the notification is past 5 working days, give the reason, example: client pending eligibility.
25. Enter the date on the Award Letter. (If late, notify due to pending client).
26. This is for HCS or CSO to mark when the Award Letter has been sent to the Hospice agency.
27. Mark the box that shows where the client lives. MAA needs the place of residence before inputting into our database. If there is more than one, list the date the client started living in each place.
28. Leave blank, this is for MAA use. (NOTE: The HCS or CSO uses this date).
29. Notes area for Hospice, HCS, CSO or MAA to communicate with each other.