Wyoming Department of Health

Hospice Benefit Election Form

Provider Name _____ **NPI/Provider Number** _____

Street Address

Provider Address _____

City State Zip Code

Provider Phone _____

Member Name _____ **Member ID** _____

Date of Hospice Election _____

Is the Member a resident in a nursing facility? ☐ Yes ☐ No

If yes:

Nursing Facility Name _____

Nursing Facility NPI/Provider Number _____

The member has been given a full understanding of Hospice care.

Other Medicaid services related to their terminal illness are waived for the duration of the election of Hospice care with the exception of home and community-based waiver services, and independent physician services.

Member Signature _____ **Date** _____ mm/dd/yyyy

Member Representative's Signature _____ **Date** _____ mm/dd/yyyy

NOTE: Attach the completed Physician Certification Statement and mail both forms to Provider Relations.

Mail completed forms to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Services
P.O. Box 1248
Cheyenne, WY 82003-1248

Submit a copy of both forms to the Long Term Care Unit via fax at (307)777-8399 or email to ltcunit@wyo.gov.