Wyoming Department of Health

Hospice Exemption Form

Hospice Provider Name _____ **Date** _____

Hospice Provider NPI/Provider Number _____ **Telephone** _____

RE: Hospice Benefit - Approval for Charges Unrelated to a Medicaid Member's Terminal Illness

The following member receiving Medicaid hospice benefits has or will soon have the following medical expenses. These expenses are not relative to the terminal diagnosis and therefore, are not the financial responsibility of the hospice provider or program. The hospice case manager has reviewed the medical necessity and is authorizing payment to the provider who furnished the service.

Member Name _____

Member ID _____ **Date of Birth** _____

Non-Hospice Benefit Diagnosis: Valid ICD diagnosis codes only. Dental providers are not required to enter diagnosis codes but must provide medical necessity and procedure codes in the "Additional explanation" section below.

Provider Providing Service

Provider Name _____

Date of Service _____ **NPI/Provider Number** _____

Procedures being performed (valid ICD, CPT, and CDT codes) or attach medical necessity.

Additional Explanation

Hospice Provider Authorized Signature _____

Printed Name _____ **Title** _____

Each non-hospice provider must submit this form with each claim being submitted to Medicaid for reimbursement.

WYBMS-Hospice Exemption Form

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