Hospice NH Room & Board Request Form
Member in Nursing Home

Hospice Provider Name ____________________ **Hospice NPI/ Provider Number** ____________

Member Name ____________________ **Member ID** ____________

Contact Name ____________________ **Contact Number** ____________

Nursing Home Name ____________________

Revenue Code	Revenue Code Description	Begin Date of Service	End Date of Service *(Less than or equal to 6 months)*
0658	Hospice R&B		

Required documentation to be submitted with this form:

Hospice Benefit Election Form or Hospice Benefit Revocation Form

Physician Statement of Terminal Illness

Name of Person Completing Form ____________________ **Date Completed** ____________

Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Relations
P.O. Box 1248
Cheyenne, WY 82003-0667