Medicaid Hospice Care
Independent Physician Review for Extended Care

Purpose:

Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 18 months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Section 1 - Patient Information: (This section can be filled in by the hospice provider.)

Patient's first name: _____ Patient's last name: _____

Medicaid ID number: _____ Patient's DOB: _____/_____/_____

Hospice provider name: _____

Section 2 - Independent physician evaluation results: (Completed by the independent physician.)

Does this patient have a terminal illness? ☐ Yes ☐ No ☐ Inconclusive

If yes, list the terminal diagnosis/es: _____

_____

_____

Please note: principle diagnoses of 'debility' or 'adult failure to thrive' will not be accepted as meeting the eligibility criteria for Medicaid hospice.

Considering the normal course of the patient's diagnosis/es, does it appear the patient's life expectancy is six (6) months or less? ☐ Yes ☐ No ☐ Inconclusive

Section 3 – Independent physician's certification statement:

I certify that I am a physician licensed in the state of Utah and that I am not affiliated with hospice agency listed in Section 1 above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face to face evaluation performed on _____(date). The conclusions listed are unbiased and free from influence.

Physician's name: _____ License #: _____

Physician's signature: _____ Date: _____

UTAH DEPARTMENT OF HEALTH