State of Illinois
Department of Healthcare and Family Services

Notification to HFS of Illinois Medicaid Hospice Benefit - Initial Election Period

The Illinois Department of Healthcare and Family Services (HFS) requires certain information from hospice agencies in order to authorize and pay for hospice care services provided to eligible participants. Completion of this form is mandatory. If a participant is covered under a managed care entity (MCE) contracted with HFS, hospice providers mus talso submit a copy of this form to the MCE. This form must be completed in its entirety or it will be returned to the provider for completion.

Section I – Complete for All Hospice Patients

The participant named on this form has elected to receive the Medicaid hospice benefit. The participant signed a notice of election form on the date identified below and has been certified by a physician as having six months or less of life expectancy if the illness follows its usual course. The notice of election form signed by the participant, and the physician certification of terminal illness statement, must comply with the requirements of 42 CFR Part 418 and HFS administrative rules at *89 Illinois Administrative Code Section 140.469.* Election statements for children through age 20 differ in that they must inform pediatric patients that they are entitled to all Medicaid benefits concurrently with hospice care. The notice of election form signed by the participant, and the physician certification of terminal illness statement are to be retained by the hospice in the patient file; however, a copy of the initial certification of terminal illness must accompany the HFS 1592.

Name - Participant (Last, First, MI)	Participant's Recipient Identification Number	Date Election for Medicaid Hospice Benefit Was Signed
Name - Hospice	Hospice's Medicaid Provider Number	Hospice's NPI

Section II - Physician Certification of Terminal Illness Statement

Please attach a copy of the physician certification of terminal illness statement that corresponds to the initial election period noted above.

Section III - Notification of Election Submission Instructions

When complete, mail or fax this form to:

Attention: UB Billing Unit
Illinois Department of Healthcare and Family Services
Bureau of Hospital and Provider Services
P. O. Box 19128
Springfield, Illinois 62794-9128

The telefax number is 217-524-4283, Attention: UB Billing Unit

Hospice Representative Signature _____ Date _____

For HFS Staff use Only:

Date Received From Hospice _____ Date Entered Into System _____ Staff Name _____