Wyoming Department of Health

# Hospice Benefit Election Form

Provider Name: _____

Provider NPI: _____ Phone Number: _____

Provider Address: _____

Provider City, State and Zip: _____

Client Name: _____

Client Medicaid ID Number: _____

Date of Hospice Election: _____/_____/_____

Is this client a resident in a nursing facility? ☐ Yes ☐ No

If yes:

Nursing Facility Name: _____

Nursing Facility NPI: _____

The client 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.

_____ _____

Client Signature Client Representative's Signature

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

Wyoming Medicaid
Attn: Provider Relations
PO Box 667
Cheyenne, WY 82003-0667

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