



Wyoming  
Department  
of Health

## Hospice Exemption Form

Date: \_\_\_\_\_

Hospice Provider Name: \_\_\_\_\_

Hospice Provider NPI: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Re: Hospice Benefit – Approval for Charges Unrelated to a Medicaid Client’s Terminal Illness**

The following client 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/program. The hospice case manager has reviewed medical necessity and is authorizing payment to the provider who furnished the service.

Client Name: \_\_\_\_\_

Client’s Medicaid ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Non-Hospice Benefit Diagnosis(es):** 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:	Provider NPI:
Date of service:	
Procedure(s) 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.

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