United Hospice Service
OF MARLETTE REGIONAL HOSPITAL

PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS FOR MEDICARE HOSPICE BENEFIT

A. Certification Statement for first 90-day period

I, Certify that _____ is under my care and to the best of my medical knowledge, given the data available, has a life expectancy of six months of less if the illness runs its normal course.

First Certification Period from: _____ to _____

X Terminal diagnosis: _____

X Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)

_____
_____
_____

Hospice standing orders to be initiated at the time of admission.

X ATTENDING PHYSICIAN, PLEASE INDICATE APPLICABLE PLAN BELOW:

_____ I will manage the total care of my patient. However, should the need arise and I am not immediately available, the hospice provider may write orders.

_____ I would prefer that the hospice provider assume medical responsibility for the care of this patient as of date of start of care.

X _____ **X** _____

(Certifying physician signature) **(Date by certifying physician)**

Print Name

_____ _____

(Hospice Medical Director Signature) **(Date by Hospice Medical Director)**

Attestation: I confirm that this narrative is based on my review of the patient's medical record and/or examination of the patient.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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