Explanation and Forms

Recertification of Terminal Illness

This document provides an explanation of the forms needed for the recertification process and examples of forms. The forms can be adapted by a hospice for the recertification of terminal illness for both the second 90-day period and for subsequent 60-day periods. The forms are designed to be downloaded and personalized for your hospice. See the description of the forms below to choose the form that best matches your hospice’s situation.

Example #1A - Hospice medical director/hospice physician recertification statement for the second 90-day period with verbal certification signature line

This is an all inclusive certification form which includes:

- The required content of the recertification of terminal illness per the regulations at 418.22
  - Specifying the terminal diagnosis is optional
- Documentation of verbal certification (if written certification is not obtained within 2 calendars days of the start of the benefit period)
  - Palmetto GBA (Medicare Administrative Contractor) requires a signature from each physician for the verbal certification.
- Hospice medical director/hospice physician printed name, signature and date for written certification
- A brief narrative statement by the hospice medical director/hospice physician
- The attestation statement for the narrative (can be documented on the certification form, or check box to indicate that the narrative is attached as an addendum to the certification form
- Hospice medical director/hospice physician printed name and signature for the written narrative statement

Example #1B - Hospice medical director/hospice physician recertification statement for the second 90-day period without verbal certification signature line

Example #2A - Hospice medical director/hospice physician recertification statement for the first 60-day and subsequent 60-day periods with verbal certification signature line

This is an all inclusive certification form which includes:

- The required content of the recertification of terminal illness per the regulations at 418.22
  - Specifying the terminal diagnosis is optional
- Documentation of verbal certification (if written certification is not obtained within 2 calendars days of the start of the benefit period)
- Hospice medical director/hospice physician printed name, signature and date for written certification
- Face to face encounter attestation
  - This must be completed by a hospice physician or hospice nurse practitioner (NP).
  - If completed by a physician, the same physician must compose the recertification narrative and sign the recertification form.
  - The attestation must specify the date of the face to face encounter and it must be signed and dated by the hospice physician or NP. The date of the encounter and the date the attestation is signed do not have to be the same date.
- A brief narrative statement by the hospice medical director/ hospice physician
- The attestation statement for the narrative (can be documented on the form, or check box to indicate that narrative is attached as an addendum to the certification form)
- Hospice medical director/ hospice physician printed name and signature for the written narrative statement

NOTE: The physician who completes the face to face encounter must be the same physician to sign the recertification of terminal illness form and compose the recertification narrative statement

Example #2B - Hospice medical director/ hospice physician recertification statement for the first 60-day and subsequent 60-day periods without verbal certification signature line

Example #2C – Nurse practitioner (NP) attestation of face-to-face encounter
If the nurse practitioner provides the face-to-face encounter, he/she must attest that the face-to-face encounter was provided and that findings were shared with the hospice physician for use in certifying the patient.

Example #3A - Hospice medical director/ hospice physician recertification narrative statement for the second 90-day period
If the brief physician narrative and attestation are not included on the recertification for the second 90 day benefit period they may be attached as a separate addendum to the recertification form. This form is an example of such an addendum to be completed by the hospice medical director/hospice physician, indicating the beneficiary’s name, the brief narrative, the attestation statement and the attending physician’s printed name, signature and the date.

Example #3B - Hospice medical director/ hospice physician recertification narrative for the first 60-day and subsequent 60-day periods
- For the first 60 days benefit period and all subsequent benefit periods, the recertification must include not only the brief physician narrative and attestation, but also documentation that a hospice physician or hospice nurse practitioner had a face to face encounter with the patient to gather clinical findings for use in determining whether the patient continues to be eligible for hospice care.
- If documentation of the face to face encounter, the brief physician narrative and attestation are not included on the recertification, they may be attached as a separate addendum to the recertification form. This form is an example of such an addendum to be completed by the hospice medical director/hospice physician, indicating the beneficiary’s name, attesting to the face to face encounter, providing the brief narrative, the attestation statement for the narrative and the attending physician’s printed name, signature and the date.
PHYSICIAN’S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT
Physician Recertification of Terminal Illness for Medicare Hospice Benefit

Recertification Statement for second 90-day period

I certify that (Beneficiary’s Name) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: ____/____/____ to ____/____/____

Terminal diagnosis: ___________________________________________ (optional)

Verbal Certification: as applicable

Hospice Medical Director/ Hospice Physician providing verbal certification of terminal illness

Date of verbal certification: ____/____/____

Hospice Medical Director/ Hospice Physician
(printed name)

Hospice Medical Director/ Hospice Physician
(signature) Date

Name/ credentials of hospice staff documenting verbal certification of terminal illness

Printed name/ credentials

Signature/ credentials Date

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

☐ Check box if attending physician composed narrative statement (physician signs below)
☐ Check box if hospice medical director/ hospice physician composed narrative statement (physician signs below)
☐ Check box if narrative and attestation statement are attached as an addendum to certification form

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

Physician (printed name) | Physician (Signature) | Date

©2010 National Hospice and Palliative Care Organization
Recertification Statement for second 90-day period

I certify that (Beneficiary’s Name) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: ____/____/____ to ____/____/____

Terminal diagnosis: ___________________________________________ (optional)

Verbal Certification: as applicable

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

☐ Check box if attending physician composed narrative statement (physician signs below)
☐ Check box if hospice medical director/ hospice physician composed narrative statement (physician signs below)
☐ Check box if narrative and attestation statement are attached as an addendum to certification form

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

Physician (printed name) | Physician (Signature) | Date
PHYSICIAN’S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT
Physician Recertification of Terminal Illness for Medicare Hospice Benefit

Physician Recertification Statement for 60-day benefit periods

I certify that (Beneficiary’s Name) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: ___/___/____ to ___/___/____ Terminal diagnosis: _____________________ (optional)

Verbal Certification: as applicable

Face to face encounter:

Hospice Physician Attestation: I confirm that I had a face-to-face encounter with (Beneficiary’s Name) on ___/___/____ and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

Brief narrative statement:

(Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)

☐ Check box if hospice medical director/ hospice physician composed narrative statement (physician signs below)

☐ Check box if narrative and attestation statement are attached as an addendum to certification form

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

©2010 National Hospice and Palliative Care Organization
PHYSICIAN’S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT
Physician Recertification of Terminal Illness for Medicare Hospice Benefit

Physician Recertification Statement for 60-day benefit periods

I certify that (Beneficiary’s Name) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: ____/____/____ to ____/____/____  Terminal diagnosis: _____________________ (optional)

Verbal Certification: as applicable

Face to face encounter:

Hospice Physician Attestation: I confirm that I had a face-to-face encounter with (Beneficiary’s Name) on ____/____/____ date and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

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

©2010 National Hospice and Palliative Care Organization
NURSE PRACTITIONER ATTESTATION OF
FACE-TO-FACE ENCOUNTER WITH BENEFICIARY

Nurse Practitioner Attestation of Face-to-Face Encounter
Name of beneficiary: _____________________________________________________

Certification period dates: ____/____/____ to ____/____/____

Hospice Nurse Practitioner Attestation: I confirm that I had a face-to-face encounter with
(Beneficiary’s Name) on (____/____/____ date) and that the clinical findings of that encounter have been
provided to the certifying physician for use in determining continued eligibility for hospice care.

<table>
<thead>
<tr>
<th>Hospice nurse practitioner (NP) (Printed name)</th>
<th>Hospice Nurse Practitioner (NP) (Signature)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PHYSICIAN’S CERTIFICATION OF TERMINAL ILLNESS FOR
MEDICARE HOSPICE BENEFIT

Physician Narrative for second 90-day period- Addendum

(Beneficiary’s Name): _____________________________________

Certification period dates: ____/____/____ to ____/____/____

Brief narrative statement:

(Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Hospice medical director/ hospice physician (printed name)</th>
<th>Hospice medical director/ hospice physician (Signature)</th>
<th>Date</th>
</tr>
</thead>
</table>

©2010 National Hospice and Palliative Care Organization
PHYSICIAN’S CERTIFICATION OF TERMINAL ILLNESS FOR
MEDICARE HOSPICE BENEFIT

Physician Narrative for second 60-day period and subsequent 60-day periods - Addendum

(Beneficiary’s Name): _____________________________________

Certification period dates: ___/___/___ to ___/___/___

Face to Face Encounter:

Attestation: I confirm that I had a face-to-face encounter with (Beneficiary’s Name) on (___/___/___date) or that a hospice nurse practitioner had a face-to-face encounter with the beneficiary on that date and provided me with clinical findings from that visit, and that I used the clinical findings of that encounter in determining (Beneficiary’s Name) continued eligibility for hospice care.

<table>
<thead>
<tr>
<th>Hospice medical director/ hospice physician (Printed name)</th>
<th>Hospice medical director/ hospice physician (Signature)</th>
<th>Date</th>
</tr>
</thead>
</table>

Brief narrative statement:
(Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)
☐ Check box if hospice medical director/ hospice physician composed narrative statement (physician signs below)
☐ Check box if narrative and attestation statement are attached as an addendum to certification form

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

<table>
<thead>
<tr>
<th>Hospice medical director/ hospice physician (printed name)</th>
<th>Hospice medical director/ hospice physician (Signature)</th>
<th>Date</th>
</tr>
</thead>
</table>