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**PHYSICIAN’S CERTIFICATION FOR MEDICARE HOSPICE BENEFIT**

**Physician Recertification of Terminal Illness for Medicare Hospice Benefit**

**Recertification Statement**

I certify that 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:

Verbal Certification: as applicable

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

Date of verbal certification: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_

Hospice Medical Director/Hospice Physician (printed name)

Name/Credentials of Hospice Staff documenting verbal certification of terminal illness

Printed Name/Credentials

Signature/Credentials Date

**Brief Narrative Statement:**

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

The client is not likely to endanger himself or herself or others as determined by a physician or other authorized health care provider. 🞎 Agree 🞎 Disagree

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

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Physician (printed name) Physician (signature) Date

Health Care. For Life. At Home Revised 2017/Reviewed 032018