Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

HOSPICE DRUG STATEMENT

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. A COPY OF THE INITIAL PLAN OF CARE AND MEDICATION RECORD MUST BE SENT WITH THIS FORM.

Beneficiary name: _____ Beneficiary Medicaid ID #: _____

Hospice diagnosis: _____

Start date of service: ____/____/_____ End date of service: ____/____/_____

Hospice provider name: _____

Hospice provider Medicaid ID #: _____ Hospice provider NPI #: _____

Hospice contact person: _____

Phone number: (_____)_____ ext _____

Indicate which drugs or medical items are **NOT** covered by hospice and indicate the medical diagnosis for which the drug or item is being prescribed. (Do not use symptoms.)
No requests will be considered without the correct diagnosis for each medication.

1. _____ DX:_____
2. _____ DX:_____
3. _____ DX:_____
4. _____ DX:_____
5. _____ DX:_____
6. _____ DX:_____
7. _____ DX:_____
8. _____ DX:_____
9. _____ DX:_____
10. _____ DX:_____

Any additional comments:

_____ _____/_____/_____
Nurse's Signature (Hospice Provider) Date

The signed statement can be mailed or faxed directly to the PA team or sent to the pharmacy.

Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

Fax: 1-800-913-2229 or 785-274-5956

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