P)719-589-9019 • F)719-589-5094 • 514 Main Street, Alamosa, CO 81101

PHYSICIAN'S CERTIFICATION OF TERMINAL ILLNESS FOR MEDICARE HOSPICE BENEFIT

Certification/Recertification Statement: For the benefit period of: ____________________________,

I certify that ____ is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

I believe this to be true because of the following clinical findings:

____

____

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____

☐ I have discussed with patient and/or family, and all are in agreement with transferring care to Hospice del Valle, Inc., Medical Director.

☐ Please admit to Hospice del Valle Services.

Attestation Statement:

By signing this certification, the physician, named below, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient

____________________________/__________________________ __________________________

(Hospice Medical Director Signature) (Please Print Name) (Date by physician)

____________________________/__________________________ __________________________

(Independent attending physician signature) (Please Print Name) (Date by physician)

Received verbal certification from *Medical Director*: Physician Name: ______________________________

Received By: ____________________________ Date:____________________

Received verbal certification from *Independent Attending Physician*: Physician Name: __________________

Received By: ____________________________ Date:_____________________

Received verbal certification from *FNP/PA*: Provider Name: ______________________________________

Received By: ____________________________ Date:____________________

Updated: 1/15/2018