NEW YORK STATE DEPARTMENT OF HEALTH
Division of Home and Community Based Services

Entity/Facility Notification of Hospice Non-Covered Items, Services, and Drugs

Section I

Hospice Agency _____

Name of Entity/Facility Receiving this Form _____

Date the Form was Shared with Entity/Facility _____

Patient Name _____ DOB: _____

MRN: _____ CIN: _____

Section II

A. Diagnoses Related to Terminal Illness and Associated Conditions
(Hospice is responsible to cover all items, services, and drugs)

1.	4.
2.	5.
3.	6.

B. Diagnoses Unrelated to Terminal Illness and Associated Conditions**

1.	4.
2.	5.
3.	6.

**Attach additional pages as needed.

Section III

Non-covered items, services, and drugs determined by hospice as unrelated to the patient's terminal illness and associated conditions**

Items	Reason for Non-Coverage

Services	Reason for Non-Coverage

Section III, continued

Drugs	Reason for Non-Coverage

**Attach additional pages as needed.

Note: The hospice decides whether the conditions, items, services, and/or drugs are related or unrelated to the terminal condition of each patient. This form should be shared with other healthcare providers, the local district as applicable, managed long term care plans and managed care plans, from which the hospice patient may seek items, services, or drugs that are deemed unrelated to the terminal illness and related conditions to assist in making treatment decisions. The information shared herein will be shared by the hospice with other Medicaid service providers.

Section IV

Name of the Individual Completing this Form _____

Title _____

Organization _____

Telephone _____

Email Address _____