MAP-378
(Rev. 12/11)

Termination of Medicaid Hospice Benefits

Hospice Benefits for _____ / _____
(Patient Name) (Member #)
are hereby terminated effective _____ for the following reason.
(Month/Day/Year)

☐ Patient is deceased. Date of death is _____ .

☐ Patient is receiving hospice services from a hospice agency which does not participate with Kentucky Medicaid/(MCO).

☐ OTHER (Please clarify)

_____ _____
Hospice Agency Provider #

_____ _____
Agency Representative Date

Submit form to the local DCBS office.

CLEAR FORM