True Hearts and Hands Hospice
(903) 422-8100 Central
(817) 435-9390 Southwest
(903) 494-5577 FAX

PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS

1. Hospice Provider Name			2. Contract No.
3. Provider Address (Street or P.O. Box, City, State, Zip)			4. Correction (Check if applicable) ☐
5. Recipient Name (Last, First, Middle)	6. DADS Medicaid No.	7. Medicare No.	8. Social Security No.
9. Election / Start Date	10. Check Appropriate Box and Enter Date (MM/DD/YYYY) ☐ Certification ☐ Recertification		11. Recipient Address Street or PO Box City State Zip

In order to provide Medicaid/Medicare Hospice coverage beginning on the recipient's election date, the recipient's terminal condition must be verified within two days of the Medicaid/Medicare Hospice Election Date as evidenced by either the physician(s) signature(s) and date(s) in the Certification section or by a Verbal Verification by the Hospice staff. When a verbal verification is obtained, a member o the Hospice staff must sign and date the Verbal Verification statement within 2 days of election; the physician(s) then must sign and date the Certification within the six (6) month terminal illness timeframe that the physician is certifying. If these requirements are not met, no payment can be made prior to the certification date (date signed by physician).
NOTE: For recertifications, only one physician's signature and date are required.

Verbal Verification (within two days of election date)

I certify that on the date signed a verbal verification was obtained from a physician licensed in the state of Texas or on duty with the United States military confirming that the recipient identified above is terminally ill with a medical prognosis of six month or less to live, if the illness runs its normal course.

12. Signature – Hospice Staff	13. Date Signed (MM/DD/YYYY)

Certification / Recertification

I certify that I am a physician licensed in the state of Texas or a physician on duty with the United States military and that the recipient identified above is terminally ill with a medical prognosis of six months or less to live, if the illness runs its normal course.

14. Print Name of Attending Physician (Last, First)

15. Signature – Attending Physician

16. Check Appropriate Box and Enter Number
☐ State of Texas License No. _____
☐ Military Spec. Code No.

17. Date Signed (MM/DD/YYYY)

18. Print Name of Hospice Physician (Last, First)

19. Signature – Hospice Physician

16. Check Appropriate Box and Enter Number
☐ State of Texas License No. _____
☐ Military Spec. Code No.

17. Date Signed (MM/DD/YYYY)

The physician member of the Hospice AND the recipient's attending physician must BOTH sign and date the Certification statement, unless the recipient does not have an attending physician separate from the Hospice physician. In that case, a member of the Hospice staff must sign the Exclusion Statement below.

Exclusion Statement

I certify that the recipient identified above DOES NO have an attending physician separate from the Hospice physician.

12. Signature – Hospice Staff	13. Date Signed (MM/DD/YYYY)