SOUTH DAKOTA MEDICAID
HOSPICE NOTIFICATION

This form must to be submitted within 5 working days of election/end of hospice services per ARSD 67:16:36:06. Submit this form via fax to:

Department of Social Services
Division of Economic Assistance
(605)773-7183

Hospice Provider Information

Provider Name: ______________________________

NPI: ______________________________

Contact Person: ______________________________

Phone Number:

Recipient Information

Recipient Name: ______________________________

Recipient ID:

Election

Begin date of hospice: ______________________________

ICD-10 diagnosis: ______________________________

Is this recipient currently in a nursing home? ☐Yes ☐No

End

End date of hospice services: ______________________________

Reason for end of services: ☐Revocation ☐Death ☐Discharge