MAP-384
(Rev. 11/22)

HOSPICE NON-RELATED DRUG FORM

Date submitted:	**Recipient Name**:	**SSN**:
Member ID:	DOB:	**Date Medicaid Hospice Coverage Began**:
Terminal Diagnosis:		**ICD-10 CM**:
Did recipient require these medication(s) prior to Hospice admission and diagnosis of the terminal illness ☐Yes ☐No		
List the diagnosis for requested medication(s) which are NOT related to the terminal illness		
Diagnosis:		**ICD-10 CM**:

List the medication(s) NOT related to the terminal illness.

Drug/Dose/Frequency	Start Date	End Date	NDC#	Units	Price Per Unit	Dispensing Fee	Total Charge	Maximum Allowance
[redacted]								

Medication(s) related to hospitalization which is NOT related to the terminal illness.

Admission Date	Discharge Date	Name of Hospital	Prescribing Physician	Medication

PROVIDER CERTIFICATION AND SIGNATURE

This is to certify that the prescriptions entered above are not related to the terminal illness of this recipient. DOCUMENTATION INDICATING THAT THESE PRESCRIPTIONS ARE NOT RELATED TO THE PATIENTS TERMINIAL ILLNESS MUST BE ATTACHED.

Signature _____ Date _____

PROVIDER INFORMATION

Name:	**Telephone #:**	**Fax#**:
Address:	**Medicaid Provider #:**	

CLEAR FORM