HOSPICE CARE RECIPIENT RESTRICTION/EXCEPTION (RR/E) CODE UPDATE FORM

In accordance with GIS 23 MA/11 and MLTC Policy 23.02,

LDSS/MMCO Name:

is requesting the following Medicaid recipient's eMedNY file be updated.

Medicaid Recipient Name:

Medicaid Recipient CIN #:

☐ **Add** C2-HOSPICE-MM RR/E code

Hospice Provider Name:

Hospice Provider MMIS: Hospice Begin Date:

☐ **Remove** C2-HOSPICE-MM RR/E code

Hospice Provider Name:

Hospice Provider MMIS: Hospice End Date:

Signature:

Signed by:

Title:

Date: Phone:

E-mail:

Send completed form to DOH via a HIPAA compliant email to:
hospicebilling@health.ny.gov