PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1153**. The time required to complete this information collection is estimated to average **10 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Hospice Item Set – Discharge

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. Add new record
2. Modify existing record
3. Inactivate existing record

A0100. Facility Provider Numbers. Enter code in boxes provided.

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

A0220. Admission Date

Month Day Year

A0250. Reason for Record

Enter Code ☐☐

01. Admission
09. Discharge

A0270. Discharge Date

Month Day Year

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

Section A Administrative Information

A0600. Social Security and Medicare Numbers

A. Social Security Number:

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number)**:**

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code

[ ]

1. Male
2. Female

A0900. Birth Date

[ ][ ] Month [ ][ ] Day [ ][ ][ ][ ] Year

A2115. Reason for Discharge

Enter Code

[ ][ ]

01. Expired
02. Revoked
03. No longer terminally ill
04. Moved out of hospice service area
05. Transferred to another hospice
06. Discharged for cause

Section Z Record Administration

Z0400. Signature(s) of Person(s) Completing the Record

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information will lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion

A. Signature:

_____

B. Date:

Month	Day	Year