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## Hospice Item Set – Discharge

<b>Section A</b>	<b>Administrative Information</b>																				
<b>A0050. Type of Record</b>																					
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	1. Add new record 2. Modify existing record 3. Inactivate existing record																				
<b>A0100. Facility Provider Numbers. Enter code in boxes provided.</b>																					
	<b>A. National Provider Identifier (NPI):</b> <input style="width: 100px; height: 20px;" type="text"/>																				
	<b>B. CMS Certification Number (CCN):</b> <input style="width: 100px; height: 20px;" type="text"/>																				
<b>A0220. Admission Date</b>																					
	<table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="6">Year</td> </tr> </table>											Month		Day		Year					
Month		Day		Year																	
<b>A0250. Reason for Record</b>																					
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	01. Admission 09. Discharge																				
<b>A0270. Discharge Date</b>																					
	<table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="6">Year</td> </tr> </table>											Month		Day		Year					
Month		Day		Year																	
<b>A0500. Legal Name of Patient</b>																					
	<b>A. First name:</b> <input style="width: 100%; height: 20px;" type="text"/>																				
	<b>B. Middle initial:</b> <input style="width: 20px; height: 20px;" type="text"/>																				
	<b>C. Last name:</b> <input style="width: 100%; height: 20px;" type="text"/>																				
	<b>D. Suffix:</b> <input style="width: 30px; height: 20px;" type="text"/>																				

**Section A****Administrative Information****A0600. Social Security and Medicare Numbers****A. Social Security Number:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**B. Medicare number (or comparable railroad insurance number):**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**A0800. Gender**

Enter Code

1. Male
2. Female

**A0900. Birth Date**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 may 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 provider 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:**

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**B. Date:**

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Month

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Day

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Year