



NC DMA Hospice Reporting



Recipient Information

DMA-0004

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____
 6. Is the recipient pending eligibility? (If checked, complete fields below)
 7. Recipient SSN: _____ Recipient County: _____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (<input checked="" type="checkbox"/>)
1			
2			
3			
4			
5			

Payer Information

8. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Provider Information

7. Requesting Provider #: _____ NPI: Atypical: 8. Taxonomy: _____
 9. Address: _____ 10. Nine Digit Zip Code: _____
 Name of Submitter: _____ Phone #: _____ Ext: _____

Service Information

11. Initial submission? OR Subsequent reporting?
 12. Effective Begin Date: _____ 13. Effective End Date: _____

Additional Information

Requesting Provider's Signature: _____ Date: _____

Fax this form to DMA at: 919-715-9025