

**Service Utilization within Hospice
 by Recipient**

LAST NAME	FIRST NAME	ADMISSION DIAGNOSIS	MEDICAID ID
VISITING SERVICES		DAYS	TOTAL DAYS/# of OFFICE VISITS
Physician Services			
Medical Director			
Consulting Physician			
Nursing Services			
Physical Therapy			
Occupational Therapy			
Speech Pathology			
Medical Social Worker			
Counseling			
Spiritual			
Bereavement			
Dietary			
Home Health Aide			
Homemaker			
Other (please explain)			
OTHER HOSPICE SERVICE COSTS		UNITS/QUANTITY	TOTAL UNITS/QUANTITY
Infusion Therapy			
Chemotherapy			
Radiation Therapy			
Medical Supplies (non-DME)			
Durable Medical Equipment (please list)			
Out-Patient Services (incl. ED visits)			
Other (please explain)			
	TRIP TYPE	TOTAL QUANTITY	
Patient Transportation			
Other (please explain) Volunteer			
	TREATMENT TYPE	TOTAL TREATMENTS	
Other (please explain)			
Drug (attach comprehensive medication profile)		LEGEND	NON-LEGEND
HOSPICE NONREIMBURSEABLE SERVICES		# of HOURS/DAYS	TOTAL # OF HOURS/DAYS
Volunteer(s) provided			
Bereavement Services (non-visit)			
Other (please explain)			

Form 282B is to be completed by the Hospice Provider within 30 days following the end of each quarter, for each recipient who died within the quarter. This form shall not be required for dual eligible hospice recipients who reside in a nursing facility.