

HOSPICE SERVICES REQUEST FOR CERTIFICATION

Please verify contract benefit information before submission of form.

Precertification for **hospice services** is required prior to **OR** within 5 days of start of care.

NAME OF HOSPICE		
After initial certification, 30-day review required unless otherwip PATIENT INFORMATION	se specified by case manager	
Patient Name		
Patient Address		
Patient Telephone		
Name of Contract Holder		
Primary Caregiver Telephone number		
Contract Number		
Secondary Insurance		
Primary Hospice Diagnosis ICD-10		
Secondary Diagnosis		
Start of Hospice		
PLACE OF CARE		
Home Care Inpatient Hospice	Respite: Inpatient Home	
SERVICES PROVIDED (indicate all and how often)		
SNMSWHHAChaplain _	TherapistMD/CRNP	
DME: Hospital bed Bedside Commode Oxygen/s	supplies BiPap Wheelchair Walker/cane Nutritional supplements	
IV fluids Wound care Other		
CLINICAL		
Disease-Specific Clinical Information	Demontia/Decreación Menuslavia IIIV	
Heart Disease Pulmonary Disease	Dementia/Progressive Neurologic HIV	
NYHA class 4 Dyspnea at rest TX: diuretics/vasodilators Right heart failure	Unable to walk	
Cardiac arrest/syncope/cva 02 sat: max 02 supp	 ·	
Documented ED visits/adm PC02 > 55	Unintentional weight loss Comorbidities	
No Transplant option Unintentional weight	-	
Liver Disease Renal Disease	ALS	
INR > 1.5 No Dialysis	Karnofsky < 40	
Albumin < 2.0 Cr clearance <10 ml/ Refractory ascites Serum Cr > 6.0		
Refractory ascites Serum Cr > 6.0 Recurrent variceal bleed	Dysphagia/unable to support life Comorbidities	
Jaundice	Comorbidities	
Malnutrition/muscle wasting		
	liagnasia for hanofit savarage*	
*Failure to thrive or generalized weakness are not eligible d	-	
History and Progression of Disease (attach clinical notes		
(Worsening symptoms, change in mental status, declining		
-	T Ht Wt BMI	
Karnofsky score 02 sats Room Air		
Progression of Diseases:		
LIORIESSIOII OI DISEASE.		
Recent laboratory data and dates: BUN/Cr	Albumin Hct/Hgb	

Medications (list all)		
Name of Drug	Dosage	Covered by Hospice (Y/N)
Patient no longer seeking aggressive treatment for	disease process, is desirin	g symptom management and
comfort care only:	Yes No	g - ,p
DND classed and an electrical beautiful and fourth	W N-	
DNR signed and understood by patient and family:	Yes No	
Has patient received Home Health or Hospice servicely If yes, name and telephone number of agency		
Other:		
Ordering MD (not Hospice Medical Director)		
Name	Provider NPI	
Office Address		
*Submit physician order for Hospice with reques		
Hospice Identification and Certification		
Hospice Name and Contact		
Address		
Telephone number	Fax	
Tax ID number		
Name of Hospice Medical Director		
Additional Information:		

FAX completed form to: 1-833-719-1609 For inquiries call: 1-833-663-8703

^{*}Continuous Care is not a covered benefit*