

Home Hospice Authorization Form

Hospice Provider	Provider Phone Number	Member's Group Name
Hospice Provider Address	Provider Fax Number	Member's Group Number
Hospice Provider Address	Provider Number	Member Number w/ Prefix

Agency Contact Name:		SOC Date:		Date of Request:	
Patient's Last Name:		First Name:	M.I.	Gender:	Date of Birth:
Address (Street, Number, City, State & Zip)		Diagnosis/Code(s):		Does patient agree to palliative, not curative, treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Contract Holder:		Do Not Resuscitate Order (DNR): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Relationship to Contract Holder: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> other (specify) _____					
Attending Physician:		Is there a primary caregiver available 24 hrs/day? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Address/Phone:		Is pt's home situation appropriate for home hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Verification of pt's life expectancy of 6 mo or less? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medications (include dose and frequency):					
Services Requested (include number of visits per day/week/month)					
<input type="checkbox"/> SN		<input type="checkbox"/> HHA		<input type="checkbox"/> SLP	
<input type="checkbox"/> MSW		<input type="checkbox"/> PT		<input type="checkbox"/> OT	
<input type="checkbox"/> Per Diem					
Physician Orders:					
Internal Office Use Only					
Certification # and Dates					
		<input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> SLP <input type="checkbox"/> Per Diem <input type="checkbox"/> Other _____			

**Important
Please Read**

1. Claims submitted for these benefits are subject to lifetime maximums, any applicable deductions, or coinsurances or provisions as specified in the contract. Benefits will be subtracted from the patient's lifetime benefits. This approval is subject to the following conditions: a) the membership is in effect at the time the services are rendered, b) these specific benefits are available under the particular contract for which the patient is insured, and c) non-exhaustion of lifetime benefits. In order to assure that benefits are available under patient's contract, please contact the appropriate benefit and eligibility verification area.
2. Payment of the claim for the approved services does not mean that future services will automatically be paid. All future claims for services similar to the above services have to be evaluated in accordance with the existing criteria.
3. If you have any questions regarding the extent of this authorization, please call (800) 334-3427 ext. 4402. Calls will be responded to within one business day.

Fax completed form to (410)720-5630 or (410)720-5641.

Please contact provider services to verify member's eligibility and benefits for the requested service.