



Home Hospice Extension Request 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:
Caregiver educated in disease process and managing care at home: Yes _____ No _____	Patient Comfortable and Pain Well Controlled? Yes _____ No _____		Nutritional Status: Good _____ Fair _____ Poor _____	
ADL's Independent _____ Needs Assist _____ Total Care _____	Ambulation _____		Independent _____ Needs Assist _____ Confined to bed/chair _____	
Continued Services Requested (include number of visits per day/week/month)				
SN _____	HHA _____	SLP _____	PerDiem _____	
MSW _____	PT _____	OT _____		
Continuous respite in home _____		Begin Date _____	thru _____	
Progress Report				
Physician's Instructions for Continued Treatment				

Internal Office Use Only	
Certification # and Dates	
	SN _____ PT _____ OT _____ MSW _____ HHA _____ SLP _____ Per Diem _____ 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.

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