HOSPICE INFORMATION FOR MEDICARE PART D PLANS

SECTION I -HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

A. Purpose of the form (please check all appropriate boxes) :												
Admission ■ Proactive Rx Communication ■ A3 Reject Override ■ Termination ■												
To: Medicare F	Part D Plan			From	From: Hospice Provider							
Plan Name					Hospice Name							
PBM Name					ess							
Phone #	() -				ie#	() -	-					
Fax #	()	-		Fax #	:	() -	-					
Secure E-Mail	E-Mail											
Contact Name				Cont	act Name							
Plan Sponsor V	Vebsite Link	::										
B. Patient Info					Prescriber	Information						
Patient Name				Prescriber Name								
Patient DOB			Prescriber NPI			NPI						
Patient ID # (HICN)			Practice Name			ame						
Hospice Admit Date			Practice Address									
Hospice Discha	arge Date				Contact Na	Contact Name						
Principal Diagn	osis Code				Practice Ph	()	-				
Other Diagnosis Code (s)						Practice Fax #)	-			
Unrelated Diagnosis				Hospice Affiliated								
Code (s)							YES L	NO				
_					Please chec	k to indicate which	i docume	nt is atta	iched.			
Notice of Elect	ion	Notice of Ter	mination /Revoca	ation								
C. Hospice Pharm	acv Benefit N	/Janager (PBM)	Information									
PBM Name		8 ()	BIN			Cardholder ID						
PBM Phone #	()	-	PCN			Group ID						
D. Prior Authoriza	tion Process	: Enter a sepa	rate line for each A	nalgesic, Ant	tinauseant (a	ntiemetic), Laxative,	and Antian	xiety dru	g (anxiolytic)			
						do not require prior						
Modication Nam	o and Strong	rth	Dosing Schedule	Quantity/	Rational	le to Support the Med	dication is I	Inrelated	l to Terminal			
Medication Name and Strength		5011	Dosing Schedule	Month	**			Jili Clatca	to reminal			
				IVIOITEII	1.108.100							
E. Signature of	Hospice Rep	resentative or	Prescriber (Requ	ired).								
Representative Date/												
Title												
Prescriber* Date / /												
	er of the me	dication is unat	ffiliated with the Ho	ospice provid	ler, has the n	rescriber confirmed						
· ·			sunrelated to the te			escriber commined		Yes	No 🗌			
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SECTION II – PLAN OF CARE (Optional)

Hospice Name		Hospice NPI								
Patient Name		Patient	ID# (HICN)	Pa	itient DOB	/ /				
Additional Medicatio Medication Name and Strength	ns Under Hospice	Hospice Pla	an of Care and Des Medication Nam	signation of Fina	incial Responsi	bility Hospice	Patient			
medication Name and others	Позрісс		Wiediedien Ham	ie una strength		П				
Signature of Hospice Representative										
Representative					Date	_//_				
Signature of Beneficiary or Beneficiary Autho	rized Repi	resentative	<u> </u>							
Beneficiary/Representative					Date	_//_				