Hospice Prior Authorization Form
Medicaid Only

Member Name: DOB: Member Phone:

Member Address:

Medicaid #:

Requesting Provider Name: Tax ID:

Address:

Clinical Contact/Title: Phone Number: Fax Number:

Servicing Provider Name: Tax ID:

Address:

Clinical Contact/Title: Phone Number: Fax Number:

Prior authorization is required for Hospice services for Members without Medicare coverage.

Date of Hospice Election: CPT code(s) Requested:

Level of Care: ☐ Routine Home Care ☐ Respite ☐ Inpatient ☐ Continuous Care

# of visits: Certifications:

Primary Hospice Diagnosis:

Related Diagnosis: Related Diagnosis:

Related Diagnosis: Related Diagnosis:

Disciplines and Frequency:

☐ Nurse Frequency: ☐ PT/OT/SLP Frequency:

☐ Hospice Aids Frequency: ☐ Social Worker Frequency:

☐ Personal Care ☐ Volunteer Services Frequency:

☐ Homemaker

DME/DMS Provided by Hospice:

☐ Bedside Commode ☐ Elevated Toilet Seat ☐ Walker ☐ Splint ☐ Oxygen ☐ Cane ☐ Wheelchair

☐ Tub/Shower Bench ☐ Grab Bars ☐ Hospital Bed ☐ Specialty Mattress ☐ Transfer Equipment

☐ Incontinence Supplies ☐ Tube feeding pump/supplies ☐ Other:

We ask that you please attach a copy of the plan of care as well as a copy of Medication List indicating what medications the hospice benefit will cover.

No Guarantee of Payment

A prior authorization of precertification does not imply or guarantee payment, nor is it a verification of a member's eligibility at the point of service. Payments of benefits are subject to all terms, conditions, limitation and exclusions of the program's contract and eligibility of the member at the time services are rendered.