



## 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:	Start Date:	End Date:
Level of Care:	<input type="checkbox"/> Routine Home Care <input type="checkbox"/> Respite <input type="checkbox"/> Inpatient <input type="checkbox"/> Continuous Care		
# of visits:	Certifications:		
Primary Hospice Diagnosis:			
Related Diagnosis:		Related Diagnosis:	
Related Diagnosis:		Related Diagnosis:	
<u>Disciplines and Frequency:</u>			
<input type="checkbox"/> Nurse	Frequency:	<input type="checkbox"/> PT/OT/SLP	Frequency:
<input type="checkbox"/> Hospice Aids	Frequency:	<input type="checkbox"/> Social Worker	Frequency:
<input type="checkbox"/> Personal Care		<input type="checkbox"/> Volunteer Services	Frequency:
<input type="checkbox"/> Homemaker			
<u>DME/DMS Provided by Hospice:</u>			
<input type="checkbox"/> Bedside Commode	<input type="checkbox"/> Elevated Toilet Seat	<input type="checkbox"/> Walker	<input type="checkbox"/> Splint
<input type="checkbox"/> Tub/Shower Bench	<input type="checkbox"/> Grab Bars	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Specialty Mattress
<input type="checkbox"/> Incontinence Supplies	<input type="checkbox"/> Tube feeding pump/supplies	<input type="checkbox"/> Other:	<input type="checkbox"/> Cane
			<input type="checkbox"/> Wheelchair
			<input type="checkbox"/> Transfer Equipment

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.

**Privacy and confidentiality:**  
 The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-6363 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.

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**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.