



Partnership Hospice Prior Authorization Medicaid Only Form

For PACE and Dual eligible FC Partnership Members **Medicaid Only**

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's care team about authorization requirements. CCI UM does not review or authorize any services for the CCI Family Care (LTC) program.

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:
Prior authorization is required for Hospice services for Members without Medicare coverage.		

Date of Hospice Election: Click or tap to enter a date.		CPT code(s) Requested:		Start Date Click or tap to enter a date.	End Date Click or tap to enter a 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:		

Privacy and confidentiality:

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Disciplines and Frequency			
<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			

DME/DMS Provided by Hospice						
<input type="checkbox"/> Bedside Commode	<input type="checkbox"/> Elevated Toilet Seat	<input type="checkbox"/> Walker	<input type="checkbox"/> Splint	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Tub/Shower Bench	<input type="checkbox"/> Grab Bars	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Specialty Mattress	<input type="checkbox"/> Transfer Equipment		
<input type="checkbox"/> Incontinence Supplies	<input type="checkbox"/> Tube Feeding pump/supplies		<input type="checkbox"/> Other:			
<p>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.</p>						

NO Guarantee of Payment

A prior authorization of precertification does not imply or guaranteed 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.

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