

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 <input type="checkbox"/> Proactive Rx Communication <input type="checkbox"/> A3 Reject Override <input type="checkbox"/> Termination <input type="checkbox"/>			
To: Medicare Part D Plan		From: Hospice Provider	
Plan Name	Allwell Dual Medicare	Hospice Name	
PBM Name		Address	
Phone #	(833) 202-4704	Phone #	
Fax #	(866) 226-1093	Fax #	
Secure E-Mail		NPI	
Contact Name		Contact Name	

Plan Sponsor Website Link: allwell.mhsindiana.com

B. Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Hospice Admit Date		Practice Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Practice Phone Number	
Other Diagnosis Code (s)		Practice Fax #	
Unrelated Diagnosis Code (s)		Hospice Affiliated	<input type="checkbox"/> YES <input type="checkbox"/> NO

For change in hospice status update documentation is required. Please check to indicate which document is attached.

Notice of Election Notice of Termination /Revocation

C. Hospice Pharmacy Benefit Manager (PBM) Information

PBM Name	BIN	Cardholder ID	
PBM Phone #	PCN	Group ID	

D. Prior Authorization Process: Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is Unrelated to Terminal Prognosis. Drugs outside of these four classes do not require prior authorization.

Medication Name and Strength	Dosing Schedule	Quantity/ Month	Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional)

E. Signature of Hospice Representative or Prescriber (Required).

Representative _____ Date ____/____/____
 Title _____

Prescriber* _____ Date ____/____/____
 *If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis? Yes No

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SECTION II – PLAN OF CARE (Optional)

Hospice Name _____ **Hospice NPI** _____

Patient Name _____ **Patient ID# (HICN)** _____ **Patient DOB** ____/____/____

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Signature of Hospice Representative

Representative _____ Date ____/____/____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative _____ Date ____/____/____