

**HOSPICE INFORMATION for MEDICARE PART D
SECTION I – INFORMATION TO OVERRIDE A3 REJECT**

To: Medicare Part D Plan Information		From: Hospice Provider Information	
Plan Name		Hospice Name	
PBM Name		Address	
Phone #	() -	Phone #	() -
Fax #	() -	Fax #	() -
Secure E-Mail		NPI	
Contact Name		Contact Name	

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Admit Date		Practice Address	
Discharge Date		Contact Name	
Admission or Discharge Update Only	<input type="checkbox"/>	Practice Phone #	() -
Primary Diagnosis		Practice Fax #	() -
Secondary Diagnosis		Hospice Affiliated	<input type="checkbox"/> YES <input type="checkbox"/> NO
Unrelated Diagnosis			

Hospice Pharmacy Benefit Manager (PBM) Information			
PBM Name		BIN	
PBM Phone #	() -	PCN	
		Cardholder ID	
		Group ID	

Medications Unrelated to Terminal Illness and/or Related Conditions: Prior Authorization Required			
Medication Name and Strength	Dosing Schedule	Qty/Month	Rationale to Support the Medication is Unrelated to Terminal Illness (Optional)

Signature of Hospice Representative or Prescriber Required.

Representative _____ Date ____/____/____

Prescriber _____ Date ____/____/____

***If the prescriber of the non-covered medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal illness and/or related conditions?** YES NO

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**HOSPICE INFORMATION for MEDICARE PART D
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"/>
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	<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 ____/____/____

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