BlueCross BlueShield Minnesota

# HOSPICE SERVICES REQUEST FOR CERTIFICATION

***Please verify contract benefit information before submission of form.***

Precertification for **hospice services** is required prior to **OR** within 5 days of start of care.

**NAME OF HOSPICE** _____

*After initial certification, 30-day review required unless otherwise specified by case manager*

## PATIENT INFORMATION

Patient Name _____

Patient Address _____

Patient Telephone _____ DOB _____

Name of Contract Holder _____

Primary Caregiver _____ Telephone number _____

Contract Number _____

Secondary Insurance _____

Primary Hospice Diagnosis _____ ICD-10 _____

Secondary Diagnosis _____

Start of Hospice _____

## PLACE OF CARE

_____ Home Care _____ Inpatient Hospice _____ Respite: Inpatient Home

## SERVICES PROVIDED (indicate all and how often)

_____SN _____MSW _____HHA _____Chaplain _____Therapist _____MD/CRNP

_____DME: Hospital bed Bedside Commode Oxygen/supplies BiPap Wheelchair Walker/cane Nutritional supplements

IV fluids Wound care Other_____

## CLINICAL

### Disease-Specific Clinical Information

Heart Disease
- ___ NYHA class 4
- ___ TX: diuretics/vasodilators
- ___ Cardiac arrest/syncope/cva
- ___ Documented ED visits/adm
- ___ No Transplant option

Pulmonary Disease
- ___ Dyspnea at rest
- ___ Right heart failure
- ___ O2 sat: max O2 support
- ___ PCO2 > 55
- ___ Unintentional weight loss

Dementia/Progressive Neurologic
- ___ Unable to walk
- ___ Dependent in ADLs
- ___ Speech < 6 intelligible words
- ___ Unintentional weight loss
- ___ Comorbid conditions

HIV
- ___ CD4 count < 25
- ___ Viral load > 100,000
- ___ Karnofsky < 40
- ___ Comorbidities

Liver Disease
- ___ INR > 1.5
- ___ Albumin < 2.0
- ___ Refractory ascites
- ___ Recurrent variceal bleed
- ___ Jaundice
- ___ Malnutrition/muscle wasting

Renal Disease
- ___ No Dialysis
- ___ Cr clearance <10 ml/min
- ___ Serum Cr > 6.0

ALS
- ___ Karnofsky < 40
- ___ Impaired pulmonary status
- ___ Dysphagia/unable to support life
- ___ Comorbidities

***Failure to thrive or generalized weakness are not eligible diagnosis for benefit coverage***

### History and Progression of Disease (attach clinical notes)

(Worsening symptoms, change in mental status, declining physical function, weight loss, etc.)

Vital signs: _____ B/P _____ P _____ R _____ T _____ Ht _____ Wt _____ BMI

Karnofsky score _____ O2 sats Room Air_____ O2 sats max O2 _____

**Brief Description:** _____

Past Medical History : _____

Progression of Disease:_____

_____

**Recent laboratory data and dates:** BUN/Cr _____ Albumin _____ Hct/Hgb _____



continue on back

**Medications (list all)**

Name of Drug | Dosage | Covered by Hospice (Y/N)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient no longer seeking aggressive treatment for disease process, is desiring symptom management and comfort care only: Yes ____ No____

DNR signed and understood by patient and family: Yes ____ No ____

Has patient received Home Health or Hospice services in the last 6 months? Yes ____ No____
If yes, name and telephone number of agency _____

**Other:** _____

**Ordering MD (not Hospice Medical Director)**

Name _____ Provider NPI _____

Office Address _____

***Submit physician order for Hospice with request for certification***

**Hospice Identification and Certification**

Hospice Name and Contact _____

Address _____ Provider NPI _____

Telephone number _____ Fax _____

Tax ID number _____

Name of Hospice Medical Director _____

Additional Information: _____

_____

_____

***Continuous Care is not a covered benefit***

**FAX completed form to: 1-833-719-1609**
**For inquiries call: 1-833-749-1967**