COUPE HEALTH

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 __________

PRO116CH-2110 Front

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