BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTH MANAGEMENT DIVISION REQUEST FOR CERTIFICATION

Please verify Contract Benefit Information before submission of form.

Hospice Services 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 and 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: _____

PMH : _____

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 Number _____

Office Address _____

Submit physician order for Hospice with request for certification

Hospice Identification and Certification

Hospice Name and Contact _____

Address _____ Provider Number _____

Telephone number _____ Fax _____

Tax ID number _____

Name of Hospice Medical Director _____

Additional Information: _____

_____

_____

Continuous Care is not a covered benefit

You may FAX completed form to: 205-402-9305
For inquiries call: 1-800-821-7231