BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

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	Pulmonary Disease	Dementia/Progressive Neurologic	HIV
___ NYHA class 4	___ Dyspnea at rest	___ Unable to walk	___ CD4 count < 25
___ TX: diuretics/vasodilators	___ Right heart failure	___ Dependent in ADLs	___ Viral load > 100,000
___ Cardiac arrest/syncope/cva	___ O2 sat: max O2 support	___ Speech < 6 intelligible words	___ Karnofsky < 40
___ Documented ED visits/adm	___ PCO2 > 55	___ Unintentional weight loss	___ Comorbidities
___ No Transplant option	___ Unintentional weight loss	___ Comorbid conditions	

Liver Disease	Renal Disease	ALS
___ INR > 1.5	___ No Dialysis	___ Karnofsky < 40
___ Albumin < 2.0	___ Cr clearance <10 ml/min	___ Impaired pulmonary status
___ Refractory ascites	___ Serum Cr > 6.0	___ Dysphagia/unable to support life
___ Recurrent variceal bleed		___ Comorbidities
___ Jaundice		
___ Malnutrition/muscle wasting		

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: 1-205-402-9305
For inquiries call: 1-855-288-8357