

**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) |
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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"/> |
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| | <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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