Federal Employee Program

REQUEST FOR CERTIFICATION*

Hospice Services *prior* **to or** *within 5 days of start of care*

* Benefit Verification: Please verify before submission of information *

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 ______________________________

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

Alzheimer Disease/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

Diagnosis not eligible for benefit coverage: Failure to thrive, dementia, generalized weakness

HISTORY AND PROGRESSION OF DISEASE (attach clinical notes)

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

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

Karnofsky score ____________ O2 sats on 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
Attach clinical information
Attach supporting documentation

Hospice Name and Contact ____

Address ____

Telephone Number__________________________ FAX _____________________

Tax ID Number ____

Name of Hospice Medical Director ______________________________________

You may FAX completed form to:
FEP Hospice Care Coordinator
at (205) 220-0859