



Federal Employee Program

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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
ICD9
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 Pulmonary Disease Alzheimer Disease/Progressive Neurologic HIV
Liver Disease Renal Disease ALS
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
Comorbidities
Recurrent variceal bleed
Jaundice
Malnutrition/muscle wasting

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

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*