



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

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 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

