



An Independent Licensee of the Blue Cross and Blue Shield Association.

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 _____

