

Hospice Authorization Request

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•
**** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS ****

Member's primary health insurance: Advanced Health OHP Dual Eligible - has Medicare and Advanced Health OHP

Member Name: _____ ID #: _____ DOB: ____/____/____

Hospice Provider: _____ Hospice Fax #: _____ PCP: _____

Certification Period: ____/____/____ to ____/____/____ *Initial certification = 90 days.
Subsequent periods are by provider request, not to exceed 90 days.

Diagnosis: _____ ICD-10 Code(s): _____

***Required**

Level of Care Requested	Days	Hours
<input type="checkbox"/> Routine Home Care (R651)		
<input type="checkbox"/> Continuous Home Care *See below (R652)		
<input type="checkbox"/> Inpatient Respite Care (R655)		
<input type="checkbox"/> General Inpatient Care (R656)		
<input type="checkbox"/> In-Home Respite Care (R659)		

***Please indicate Plan of Care for Continuous Home Care:**

Signature of Requesting Provider: _____ Date ____/____/____

OR

Signature of Requesting Non-Physician Provider: _____ Date ____/____/____

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.

For Advanced Health Use Only:

Disposition of Authorization

Approved as requested Approved Date Range: ____/____/____ to ____/____/____

Level of Care Requested	Days	Hours
<input type="checkbox"/> Routine Home Care (R651)		
<input type="checkbox"/> Continuous Home Care *See below (R652)		
<input type="checkbox"/> Inpatient Respite Care (R655)		
<input type="checkbox"/> General Inpatient Care (R656)		
<input type="checkbox"/> In-Home Respite Care (R659)		

Medical Management Staff Signature: _____ Date: ____/____/____

Faxed via: System: _____ Manual: _____

Denial Reason

Patient not eligible on date of admit Retro authorization (criteria not met)

Requested Information not received

Other: _____

Medical Director Signature (required for denied referrals): _____ Date: ____/____/____

D PII MC Date ____/____/____ NOA Date: ____/____/____ Initials: _____

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