Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Hospice Authorization Request

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

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

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

Hospice Provider NPI#: _____

Certification Period: _____/_____/_____ to _____/_____/_____

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

Level of Care Requested	Days	Hours
☐ Routine Home Care (651)		
☐ Continuous Home Care *See below (652)		
☐ Inpatient Respite Care (655)		
☐ General Inpatient Care (656)		
☐ In-Home Respite Care (659)		

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

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

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

(Rev 12/20)