HOSPICE

Authorization Request Form
Fax Completed Form to: 855-573-2346

Please check type of request:

Initial Request ___ Reauthorization ___ Agency Transfer ___ MCO Transfer ___

Original Date Submitted to MCO: _____

MEMBER DEMOGRAPHIC INFORMATION

WellCare ID	Last Name	First Name	DOB
Emergency Contact Name and Contact #:		Medicaid/Medicare ID: **Is the Member DSNP: YES or NO**	
Additional Primary Insurance Name:		Policy #: Contact #:	

HOSPICE PROVIDER INFORMATION

Provider Name	Provider Contact:	Contact #:
Provider Address	City, State	ZIP Code
Is the member home?	Yes *If yes, provide address.*	No
Street Address	City, State	ZIP Code
Is the member in a facility?	Yes *If yes, provide name and address.*	No
Facility Name:	Facility Address:	Phone #:

DX CODE(S):_____PROCEDURE/CPT: T2042 or T2046

Please list any dates of transition of care or discharges from hospice

CLINICAL SUMMARY: PLEASE ATTACH DOCUMENTATION FOR MEDICAL NECESSITY AND PHYSICIAN'S ORDER