

Hospice/End-Stage Renal Disease (ESRD) Placement Referral Report Form



Practice/Physician Name: _____

Phone/Fax Numbers: _____

Member Name: _____

Member ID#: _____

Effective Date of Hospice/ESRD Enrollment: _____

Diagnosis: _____

Attending Physician: _____

Hospice/Dialysis Name: _____

Address: _____

Phone/Fax Numbers: _____

Comments:

Fax to: **Attn: Health Services** (888) 881-8225



Completed by Plan:

Authorization Number and Date: _____

Completed By and Date: _____

Note: Please include backup documentation, i.e., Proof of Hospice Election form, CMS form 1450-Notice of Election and/or Form 2728-Medical Evidence of ESRD.