



**HOSPICE INFORMATION FOR MEDICARE PART D PLANS**

**SECTION I -HOSPICE INFORMATION TO OVERRIDE AN “HOSPICE A3 REJECT” OR TO UPDATE HOSPICE STATUS**

**A. Purpose of the form (please check all appropriate boxes):**  
**Admission**  **Proactive Rx Communication**  **A3 Reject Override**  **Termination**

<b>To: Medicare Part D Plan</b>		<b>From: Hospice Provider Information</b>	
Plan Name	HealthSun Health Plans	Hospice Name	
PBM Name	IngenioRx	Address	
Phone #	(877) 336-2069	Phone #	( ) -
Fax #	(844) 430-1705	Fax #	( ) -
		NPI	
Contact Name	Part D Services Department	Contact Name	
Plan Sponsor Website Link: www.HealthSun.com			

<b>B. Patient Information</b>		<b>Prescriber Information</b>	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Name	
Hospice Admit Date		Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Phone Number	( ) -
Other Diagnosis Code (s)		Fax #	( ) -
Unrelated Diagnosis Code (s)		Hospice Affiliated	YES <input type="checkbox"/> NO <input type="checkbox"/>

**For change in hospice status update documentation is required. Please check to indicate which document is attached.**  
 Notice of Election  Notice of Termination /Revocation

**C. Hospice Pharmacy Benefit Manager (PBM) Information**

PBM Name		BIN		Cardholder ID	
Phone #	( ) -	PCN		Group ID	

**D. Prior Authorization Process:** Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is **Unrelated** to Terminal Prognosis . Drugs outside of these four classes do not require prior authorization.

Medication Name and Strength	Dosing Schedule	Quantity/ Month	Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional)

**E. Signature of Hospice Representative or Prescriber (Required).**

Representative \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Title \_\_\_\_\_

Prescriber\* \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

\* If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis?

Yes  No

**SECTION II – PLAN OF CARE  
(Optional)**

Hospice Name \_\_\_\_\_ Hospice NPI \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient ID# (HICN) \_\_\_\_\_ Patient DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

**Signature of Hospice Representative**

Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Beneficiary or Beneficiary Authorized Representative**

Beneficiary/Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500). HealthSun Health Plans is an HMO plan with a Medicare contract.

Enrollment in HealthSun Health Plans depends on contract renewal.