FORM APPROVED OMB NO 0938-1269
Expiration 2/28/2022

HealthSun HEALTH PLANS

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** ☐

To: Medicare Part D Plan		From: Hospice Provider Information	
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. Patient Information		Prescriber Information	
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 ☐ NO ☐	

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
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Signature of Hospice Representative

Representative _____ Date____/_____/_____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative _____ Date____/_____/____