



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 <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 ____/____/____