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	
Plan Name	Allwell	Hospice Name	
PBM Name		Address	
Phone #	1-844-890-2326	Phone #	
Fax #	1-866-226-1093	Fax #	
Secure E-Mail		NPI	
Contact Name		Contact Name	

Plan website: allwell.pshpgeorgia.com

B. Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Hospice Admit Date		Practice Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Practice Phone Number	
Other Diagnosis Code (s)		Practice 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	
PBM 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 ☐

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

Signature of Hospice Representative

Representative_____Date____/_____/_____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative_____Date____/_____/_____