**HOSPICE STATUS and PLAN OF CARE for MEDICARE PART D A3 REJECT OVERRIDE**

**SECTION I**

|  |  |
| --- | --- |
| **To: Medicare Part D Plan Information** | **From: Hospice Provider Information** |
| Plan Name |         | Hospice Name |       |
| PBM Name |       | Address |       |
| Phone # | (    )    -     | Phone # | (    )    -     |
| Fax # | (    )    -     | Fax # | (    )    -     |
| Secure E-Mail  |       | NPI |       |
| Contact Name |       | Contact Name |       |

|  |  |
| --- | --- |
| **Patient Information**  | **Prescriber Information**  |
| Patient Name |  | Prescriber Name |  |
| Patient DOB | **/   /** | Prescriber NPI |  |
| Patient ID# (HICN) |  | Practice Name |  |
| Admit Date | **/   /** | Practice Address |  |
| Discharge Date  | **/   /** | Contact Name |  |
| **Admission or Discharge Update Only** **[ ]**  | Practice Phone # | (    )    -     |
| Primary Diagnosis  |  | Practice Fax # | (    )    -     |
|  |  | Hospice Affiliated | [ ]  YES [ ]  NO |
| Secondary Diagnosis  |  |  |
| Unrelated Diagnosis |  |  |
|  |  |  |  |

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| --- |
| **Hospice Pharmacy Benefit Manager (PBM) Information** |
| PBM Name |  | Bin |  | Cardholder ID |  |
| PBM Phone # | (    )    -     | PCN |  | Group ID |  |

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| --- |
| **Medications Un-related to Terminal Illness: Part D A3 Reject Override Required**  |
| Medication Name and Strength | Dosing Schedule | Qty/Month | Rationale for Treatment  |
|  |  |  |  |
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|  |  |  |  |

Signature of Hospice Representative or Prescriber required.

Representative       Date**/   /**

Prescriber      NPI Date**/   /**

**\*If the prescriber of the non-covered medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal illness or related conditions?** [ ]  YES [ ]  NO

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**HOSPICE STATUS and PLAN OF CARE for MEDICARE PART D A3 REJECT OVERRIDE**

**SECTION II**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospice Name |  | Hospice NPI |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name |  | Patient ID#(HICN) |  | Patient DOB |  **/  /** |

|  |
| --- |
| **Additional Medications Under Hospice Plan of Care and Designation of Responsible Party** |
| Medication Name and Strength | Hospice | Patient | Medication Name and Strength | Hospice | Patient |
|  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  |
|  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  |
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|  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  |
|  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  |

Signature of Hospice Representative

Representative       Date   /  /

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