**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 |  |  | |
|  |  |  |  |

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

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

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

\*This fax is intended for the use of the individual or entity to which it is addressed. It may contain confidential information that is privileged and exempt from disclosure under State and Federal law. If you are not the intended recipient, distribution or copying of this communication is strictly prohibited.

**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 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Signature of Hospice Representative

Representative       Date   /  /

\*This fax is intended for the use of the individual or entity to which it is addressed. It may contain confidential information that is privileged and exempt from disclosure under State and Federal law. If you are not the intended recipient, distribution or copying of this communication is strictly prohibited.