HOSPICE INFORMATION for MEDICARE PART D
SECTION I – INFORMATION TO OVERRIDE A3 REJECT

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 #	( ) -
Secondary Diagnosis		Hospice Affiliated	☐ YES ☐ NO
Unrelated Diagnosis			

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

Medications Unrelated to Terminal Illness and/or Related Conditions: Prior Authorization Required			
Medication Name and Strength	Dosing Schedule	Qty/Month	Rationale to Support the Medication is Unrelated to Terminal Illness (Optional)

Signature of Hospice Representative or Prescriber Required.

Representative _____ Date_____/_____/_____

Prescriber _____ 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 and/or related conditions?** ☐ YES ☐ NO

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HOSPICE INFORMATION for MEDICARE PART D
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_____/_____/_____

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