Excellus

Hospice
Medicare - Part D

Complete this form & fax to:
Fax #: 1-800-956-2397
Phone #: 1-800-499-1275

Urgent Requests Only:
Fax #: 1-800-208-4050

SECTION I – HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

A. Purpose of this form (Check all appropriate boxes)			
☐ Admission	☐ Proactive Rx	☐ A3 Reject Override	☐ Termination

To: Medicare Part D Plan		**From: Hospice Provider**	
Plan Name		Hospice Name	
PBM Name		Address	
Phone #	(800) 363-4658	Phone #	( )
Fax #	(800) 956-2397	Fax #	( )
Secure Email		NPI #	
Contact Name		Contact Name	
Plan Sponsor Website Link: Home | Providers | Excellus BlueCross BlueShield (excellusbcbs.com)			

B. Patient Information		**Prescriber Information**	
Patient Name		Prescriber Name:	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Hospice Admission Date		Practice Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Practice Phone Number	( ) Ext:
Other Diagnosis Code (s)		Practice Fax #	( )
Unrelated Diagnosis Code (s)		Hospice Affiliated	

For Change In Hospice Status Update Documentation is Required (*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). Any Medication unrelated to Terminal Prognosis. *Drugs outside of these 4 classes do not require prior authorization)

Medication Name	Dose	Dosing Schedule	Quantity/Month	Rationale to support the medications is unrelated to Terminal Prognosis

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**

Continue onto the next page

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HOSPICE INFORMATION FOR MEDICARE PART D PLANS

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	Dose	Hospice	Patient	Medication Name	Dose	Hospice	Patient
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Signature of Hospice Representative: _____ Date: _____/_____/_____

Signature of Beneficiary or Authorized Representative: _____ Date: _____/_____/_____