AdventHealth Advantage Plans
Health First Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myAHplan.com

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		Hospice name	
PBM Name		Address	
Phone #	( ) -	Phone #	( ) -
Fax #	( ) -	Fax #	( ) -
Secure email		NPI	
Contact Name		Contact Name	
Plan Sponsor Website Link:			

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 #	( ) -
Other diagnosis code (s)		Practice fax #	( ) -
Unrelated diagnosis codes (s)		Hospice affiliated	☐ YES ☐ NO

For change in hospice status update documentation is required. Please check and 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 anti-anxiety 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
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Signature of Hospice Representative

Representative ____ Date_____/_____/_____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative ____ Date_____/_____/_____

AdventHealth Advantage Plans is administered by Health First Health Plans. Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal. Y0089_MPINFO7411AH_C(08/19)