Hospice Authorization Form

For Family Care Partnership (Medicaid Only)

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	D.O.B:	Medicaid ID #:
Member Phone:	Member Address:	
Requesting Provider Name/Clinic:		
Address:		
Clinical Contact/Title:	Phone Number:	Fax Number:
Servicing Provider Name/Clinic:		
Tax ID:		NPI #:
Address:		
Clinical Contract/Title:	Phone Number:	Fax Number:
Authorization is required for Hospice services for Members without Medicare coverage.		

Date of Hospice Election:		CPT code(s) Requested:	Start Date	End Date
Level of Care:	☐ Routine Home Care	☐ Respite	☐ Inpatient	☐ Continuous Care
# of Visits:		Certifications:		
Primary Hospice Diagnosis:				
Related Diagnosis:		Related Diagnosis:		
Related Diagnosis:		Related Diagnosis:		

Privacy and confidentiality: The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation

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Disciplines and Frequency			
☐ Nurse	Frequency:	☐ PT/OT/SLP	Frequency:
☐ Hospice Aids	Frequency:	☐ Social Worker	Frequency:
☐ Personal Care		☐ Volunteer Services	Frequency:
☐ Homemaker			

DME/DMS Provided by Hospice						
☐ Bedside Commode	☐ Elevated Toilet Seat	☐ Walker	☐ Splint	☐ Oxygen	☐ Cane	☐ Wheelchair
☐ Tub/Shower Bench	☐ Grab Bars	☐ Hospital Bed	☐ Specialty Mattress	☐ Transfer Equipment		
☐ Incontinence Supplies	☐ Tube Feeding pump/supplies		☐ Other:			
We ask that you please attach a copy of the plan of care as well as a copy of Medication List indicating what medications the hospice benefit will cover.						

NO Guarantee of Payment

An authorization of precertification does not imply or guaranteed payment, nor is it a verification of a member's eligibility at the point of service. Payments of benefits are subject to all terms, conditions, limitation and exclusions of the program's contract and eligibility of the member at the time services are rendered.

205 Bishops Way, Brookfield, WI 53005 ● Phone: 262-207-9393 ● Fax: 414-384-8272