Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Hospice Authorization Request

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•

**** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS ****

Member's primary health insurance: Advanced Health OHP☐ Dual Eligible - has Medicare and Advanced Health OHP☐

Member Name: _____ ID #: _____ DOB: _____/_____/_____

Hospice Provider: _____ Hospice Fax #: _____ PCP: _____

Certification Period: _____/_____/_____ to _____/_____/_____ ***Initial certification = 90 days. Subsequent periods are by provider request, not to exceed 90 days.**

Diagnosis: _____ ICD-10 Code(s):_____ _____ _____

***Required**

Level of Care Requested	Days	Hours
☐ Routine Home Care (R651)		
☐ Continuous Home Care *See below (R652)		
☐ Inpatient Respite Care (R655)		
☐ General Inpatient Care (R656)		
☐ In-Home Respite Care (R659)		

***Please indicate Plan of Care for Continuous Home Care:**

Signature of Requesting Provider:_____ Date _____/_____/_____

OR

Signature of Requesting Non-Physician Provider: _____ Date _____/_____/_____

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, con tract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.

For Advanced Health Use Only:

Disposition of Authorization

☐ Approved as requested Approved Date Range: _____/_____/_____ to _____/_____/_____

Level of Care Requested	Days	Hours
☐ Routine Home Care (R651)		
☐ Continuous Home Care *See below (R652)		
☐ Inpatient Respite Care (R655)		
☐ General Inpatient Care (R656)		
☐ In-Home Respite Care (R659)		

Medical Management Staff Signature:_____ Date: _____/_____/_____

Faxed via: System: _____ Manual: _____

☐ Denial Reason

☐ Patient not eligible on date of admit ☐ Retro authorization (criteria not met)

☐ Requested Information not received

☐ Other: _____

Medical Director Signature (required for denied referrals): _____ Date: _____/_____/_____

D PII MC Date _____/_____/_____ NOA Date: _____/_____/_____ Initials: _____