Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Hospice Prior Authorization Request

This fax from agency listed below sent to DHHS and returned to said agency by DHHS Medicaid Prior Authorization Department after approval. Attached transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., § 68-31. If this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

Type of Prior Authorization Request: ☐ Initial ☐ Recertification ☐ Additional service request to PA

Client Medicaid Number:	Client Name:
NPI:	Provider Name/Location:
Taxonomy:	Zip + 4:
County of Client:	Provider Phone/Fax Number:
ICD Indicator: ☐ ICD-9 ☐ ICD-10	Primary Diagnosis Code:
Authorization Period: to	

This authorization includes the following services at the indicated number of units:

Service	Code	# of Units
Routine Home Care	T2042	180 days/certification period
Continuous Home Care	T2043	72 hours
Inpatient Respite Care	T2044	5 days/month
General Inpatient Care	T2045	10 days/month

Does the Client have Medicare A? ☐ Yes ☐ No

If "Yes", list date and reason Medicare A Hospice Benefits exhausted_____

Have the following been notified of Hospice involvement?

Pharmacy? ☐ Yes ☐ No Comments_____

Equipment? ☐ Yes ☐ No Comments_____

Other suppliers ☐ Yes ☐ No Comments_____

Is Client on Managed Care? ☐ Yes ☐ No

Is Client on Medicaid Waiver? ☐ Yes ☐ No

If Client resides in or moves to a long term care facility (NF, AL, CDD, ICF/MR or IMD):

FacilityName/Location:_____

Hospice Provider Number for that Facility (if applicable):_____

Has Facility Billing Office been notified of Hospice involvement? ☐ Yes ☐ No

Is there a signed contract between Facility and Hospice Provider? ☐ Yes ☐ No

List Effective Date of Contract: _____

Other Medicaid Services provided to client: _____

Attachments to this request (Required):

- ☐ Signed Election Statement
- ☐ Physician Certification of Terminal Illness with Life Expectancy of 6 months or less
- ☐ Hospice Plan of Care
- ☐ Listing of all medications, biologicals, supplies, and equipment for which hospice is covering
- ☐ Clinical Criteria to support terminal status or supportive documentation for functional decline

*Prior Authorization: Void if client not Medicaid Enrolled
*Not valid if Share of Cost is met if client has excess income
*If client is on Medicaid Waiver, please contact Services Coordinator for Continued Coordination