FORM APPROVED OMB NO 0938-1269
Expiration 2/28/2022

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) :

Plan Name	Aetna Better Health of Virginia (HMO D-SNP)	Hospice Name	
PBM Name		Address	
Phone #	(855) 463-0933	Phone #	( ) -
Fax #	(877) 270-0148	Fax #	( ) -
Secure E-Mail		NPI	
Contact Name		Contact Name	
Plan Sponsor Website Link:			

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 Number	( ) -
Other Diagnosis Code (s)		Practice Fax #	( ) -
Unrelated Diagnosis Code (s)		Hospice Affiliated	☐ YES ☐ NO

PBM Name		BIN		Cardholder ID	
PBM Phone #	( ) -	PCN		Group ID	

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 ☐

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 and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
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Signature of Hospice Representative

Representative____Date____/_____/________

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative____Date____/_____/________