



CalOptima Health

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*For CalOptima Use Only*  
**REFERENCE NO:** \_\_\_\_\_

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**Status:**  Request Validated  Denied  
 Modified  Deferred  
**From:** \_\_\_\_\_ **To:** \_\_\_\_\_

### Hospice Notification/Validation Form (HNVF)

Initial Validation (90 days)  Re-certification  Retroactive

#### **SECTION I**

**PROVIDER: Notification/Validation does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.**

**Patient Name:** \_\_\_\_\_  M  F **D.O.B.** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Client Index #:** \_\_\_\_\_ **Aid Code:** \_\_\_\_\_ **County Code:** \_\_\_\_\_

<b>Hospice Provider:</b>	<b>Physician Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>Phone:</b>	<b>Phone:</b>
<b>Fax:</b>	<b>Physician Medi-Cal ID #:</b>
<b>Medi-Cal Provider ID #:</b>	<b>Diagnosis Code:</b>
<b>Office Contact:</b>	

**Hospice Start Date:** \_\_\_\_\_ **Dates of Service: From:** \_\_\_\_\_ **To:** \_\_\_\_\_

#### **SECTION II**

**Hospice Billing Codes:** **# of Units (Days)**

0651 Routine Home Care \_\_\_\_\_

0652 Continuous Home Care \_\_\_\_\_

0655 Respite Care \_\_\_\_\_

0656/T2045 General Inpatient Care \_\_\_\_\_

0657 Special Physician Services \_\_\_\_\_

0658 Hospice Room and Board \_\_\_\_\_

G0155 Clerical Social Worker Services \_\_\_\_\_

G0299 Registered Nurse Services \_\_\_\_\_

Other \_\_\_\_\_

#### **SECTION III**

**Place of Service**  
 SNF  Yes or  No  
 If Yes, Name of Facility: \_\_\_\_\_

Home  Yes or  No

#### **SECTION IV**

**Documentation Attached:**

Written order signed by attending physician

Patient's Hospice Election Form

Initial Written Plan of Care

Certification of Terminal Illness by M.D.

DHS 6194

Face-to-Face Encounter

#### **SECTION V**

Election Date: \_\_\_\_\_

Revocation Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Other: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE FOR CalOptima USE ONLY**

**COMMENTS:**  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_