CalOptima Health

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HOSPICE NOTIFICATION FORM (HNF)

☐ INITIAL CERTIFICATION ☐ RECERTIFICATION ☐ RETROACTIVE ELIGIBILITY

SECTION I

HOSPICE ADMISSION: _____ **DATE OF SERVICE FROM:** _____ **TO:** _____

PROVIDER: Notification does not guarantee payment.
CalOptima Health eligibility must be verified at the time services are rendered.

MEMBER NAME: _____ ☐M ☐F **DOB:** _____ **AGE:** _____
LAST FIRST

MAILING ADDRESS: _____ **CITY:** _____ **ZIP:** _____

CIN: _____ **AID CODE:** _____ **COUNTY CODE:** _____

HOSPICE PROVIDER: _____

ADDRESS: _____

PHONE: _____

FAX: _____

MEDI-CAL PROVIDER ID: _____

OFFICE CONTACT: _____

PHYSICIAN NAME: _____

ADDRESS: _____

PHYSICIAN MEDI-CAL ID: _____

PHONE: _____

TERMINAL DIAGNOSIS ICD-10 CODE: _____

_____

SECTION II Hospice Billing Code:

- ☐ **0552** – Routine Home Care *(service intensity add-on)*
- ☐ **0650** – Routine Home Care (high rate)
- ☐ **0659.49** – Routine Home Care (low rate)
- ☐ **0652** – Continuous Home Care
- ☐ **0655** – In-Patient Respite Care
- ☐ **0657** – Physician Services

SECTION III Attached Documents:

- ☐ Certification of Terminal Illness by Attending Physician
- ☐ Signed Medi-Cal Hospice Program Election
- ☐ Face-to-Face Encounter
- ☐ Member's Initial Plan of Care
- ☐ DHS 6194 Hospice General Inpatient Information Sheet

SECTION IV

Place of Service:

SNF ☐ Yes or ☐ No

If Yes, Name of Facility:

_____

Home ☐ Yes or ☐ No

SECTION V

- ☐ Election Date: _____
- ☐ Revocation Date: _____
- ☐ Expiration Date: _____
- ☐ Other: _____