



Commercial Hospice Services Request

Note: When prior authorization is required and services are needed beyond the original services authorized by us, you must request the continuation of services before the initial authorization of services ends.

Member Information

Member Name: _____ Date of Birth: ____/____/____

Subscriber ID: _____

Care Management Contact Information

Member Name: _____

Phone: (____)____-____ Fax: (____)____-____

Diagnosis (including ICD-10-CM Code):

Provider Information

Ordering Physician: _____

Address: _____ City: _____ State: ____ ZIP Code: _____

NPI: _____ Phone Number #: _____

Tax ID: _____ Phone: (____)____-____ Fax: (____)____-____

Hospice Provider: _____

Address: _____ City: _____ State: ____ ZIP Code: _____

NPI: _____ Phone Number #: _____

Tax ID: _____ Phone: (____)____-____ Fax: (____)____-____

Services Requested (indicate all services requested and complete the dates/number of visits)

Name	From Date	To Date	# Visits
Respite (FHL3)			
General Inpatient Hospice (FHL4)			

Request Type:

Initial Extension

MD signed Certificate of Illness attached:

Yes No

If Extension: Current case #: _____

Will send when available _____

Provider Information

*By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717, option 2**, or contact your eBusiness Network Manager.