Hospice Control Form Attachment

After completion, fax to 717.346.6870.

☐ Approved

Patient's Name: _____

Contract Number: _____

Provider Name and Address: _____

_____

_____

Provider Number: _____

Provider Phone Number: _____

Provider Fax Number: _____

Hospice Contact: _____

Contact Number: _____

Diagnosis: _____

Start of Care: _____

Date of Death/Discharge: _____

Attending Physician: _____

Physician's Address and Phone Number: _____

_____

_____

☐ Traditional Home Hospice (home hospice services; 90-day timeframe)

☐ Continuous Hospice (period of crisis requiring minimum of eight hours of care each 24-hour period; seven-day timeframe for approval)

☐ Inpatient Hospice (provided by a facility licensed as inpatient hospice facility; up to 30 days)

__Required__ Treatment plan (485) including the services to be provided, medication list, DME, current treatment, (e.g., radiation or chemo) **must** be faxed prior to the start of care.

***In addition, the signed certification from the physician **must** be faxed.

Please fax any notifications of significant change to 717.346.6870.