Nevada Medicaid and Nevada Check Up

Hospice Prior Authorization Request

Purpose: To request prior authorization for Hospice services through the Nevada Medicaid program. This form must be submitted through the Provider Web Portal with Hospice forms FA-92 or FA-93, and FA-94.

Required Attachments: Please attach an Individualized Plan of Care and Measurable Treatment Goals. Nevada Medicaid will require that the other in-home service providers (Private Duty Nursing, Home Health, Personal Care Services) cooperate in the coordination efforts and understand that the hospice provider is the lead case coordinator. For recipients under age 21 who have elected Hospice services and curative interventions, the Hospice Plan of Care should include all necessary palliative interventions (all interventions provided for the purpose of symptom control, or to enable the recipient to maintain Activities of Daily Living (ADLs) and basic functional skills). Examples of these non-curative, non-life prolonging interventions include but are not limited to: bathing / dressing / diapering / transferring / nebulizer treatments / chest vest treatments / applying braces / performing range of motion exercises / stander use.

For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ **/**_____ **/**_____

If this is an initial request, a Pre-Admission face-to-face visit by a medical professional must have been conducted within the previous 15 days. Date and time of visit:_____

Name of assessing medical professional:_____

REQUEST TYPE: ☐ Initial 90-Day Period ☐ Subsequent 90-Day Period ☐ Subsequent 60-Day Period

Current prior authorization (PA) number, if applicable: _____

NOTES:	
SECTION I: RECIPIENT INFORMATION	
Recipient Name:	
Recipient ID:	Date of Birth:
Medicaid Eligibility: ☐ Healthy Kids (EPSDT) ☐ Katie Beckett ☐ Waiver Program ☐ Managed Care	
Medicare Insurance Eligibility: ☐ Part A ☐ Part B	Medicare ID#:
Bypass Medicare: ☐ Yes ☐ No	
Other Insurance Name:	Other Insurance ID#:
Bypass Other Insurance: ☐ Yes ☐ No	
SECTION II: GUARDIAN INFORMATION *(if other than the recipient)*	
Name:	Phone:
Address *(include city, state, zip code)*:	
SECTION III: LONG-TERM CARE FACILITY *(if applicable)*	
☐ Long-Term Care Facility	Facility Name:
Facility Address:	
Facility NPI:	Contact Fax:
SECTION IV: ORDERING PROVIDER INFORMATION *(if applicable)*	
Name:	NPI:
Phone:	Fax:
SECTION V: SERVICING PROVIDER INFORMATION	
Name:	NPI
Phone:	Fax:
Contact Name:	Miles from Hospice Agency to Recipient's Home:
Where does this provider render services? ☐ In Nevada (includes catchment areas) ☐ Outside Nevada	

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SECTION VI: CLINICAL INFORMATION	
Date of Registered Nurse Evaluation:	Date of Last Physician Visit:
Terminal Diagnoses ICD-10 Codes:	

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.