



Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Hospice Authorization Request

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Member Name: _____ Mediciad ID #: _____ DOB: ____/____/____

Hospice Provider: _____ Hospice Fax #: _____ PCP: _____

Hospice Provider NPI#: _____

Certification Period: ____/____/____ to ____/____/____

Diagnosis: _____ ***Required**
ICD-10 Code(s): _____

Level of Care Requested	Days	Hours
☐ Routine Home Care (651)		
☐ Continuous Home Care *See below (652)		
☐ Inpatient Respite Care (655)		
☐ General Inpatient Care (656)		
☐ In-Home Respite Care (659)		

*Please indicate Plan of Care for Continuous Home Care:

Signature of Requesting Provider: _____ Date ____/____/____

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.