CalOptima
Public Agency
Better. Together.

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For CalOptima Use Only REFERENCE NO:	*For CalOptima Use Only* Status: ☐ Request Validated ☐ Denied ☐ Modified ☐ Deferred From: To:

Hospice Notification/Validation Form (HNVF)

☐ Initial Validation (90 days) ☐ Re-certification ☐ Retroactive

SECTION I

PROVIDER: Notification/Validation does not guarantee payment.
CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Social Security #: **Client Index #:** **Aid Code:** **County Code:**

Hospice Provider:	**Physician Name:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Physician Medi-Cal ID #:**
Medi-Cal Provider ID #:	**Diagnosis Code:**
Office Contact:	

Hospice Start Date: **Dates of Service:** **From:** **To:**

SECTION II

Hospice Billing Codes: **# of Units (Days)**

- ☐ 0651 Routine Home Care
- ☐ 0652 Continuous Home Care
- ☐ 0655 Respite Care
- ☐ 0656/T2045 General Inpatient Care _____
- ☐ 0657 Special Physician Services _____
- ☐ 0658 Hospice Room and Board _____
- ☐ G0155 Clerical Social Worker Services _____
- ☐ G0299 Registered Nurse Services _____
- ☐ Other

SECTION III

Place of Service

SNF ☐ Yes or ☐ No

If Yes, Name of Facility: _____

Home ☐ Yes or ☐ No

SECTION IV

Documentation Attached:

- ☐ Written order signed by attending physician
- ☐ Patient's Hospice Election Form
- ☐ Initial Written Plan of Care
- ☐ Certification of Terminal Illness by M.D.
- ☐ DHS 6194
- ☐ Face-to-Face Encounter

SECTION V

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

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:** **Phone Number:**