



HOSPICE/ESRD PLACEMENT REFERRAL REPORT

Practice/Physician Name: _____

Phone/Fax Numbers: _____

Member Name: _____

Member ID#: _____

Effective Date of Hospice/ESRD Enrollment: _____

Diagnosis: _____

Attending Physician: _____

Hospice/Dialysis Name: _____

Address: _____

Phone/Fax Numbers: _____

Comments:

Fax to: Attn: Health Services (866) 287-3286

Completed by Plan: _____

Authorization # and Date: _____

Completed By and Date: _____

Note: Should include back up documentation i.e., proof of hospice election form, CMS form 1450-Notice of Election and/or form 2728-Medical Evidence of ESRD.