

PROVIDER PORTAL USER GUIDE

Hospice Requests & Notifications

Authorization requests and notifications for hospice services can be easily submitted on SFHP’s Provider Portal. A detailed user guide is available in the portal under [Provider Resources](#).

Effective November 1, 2025, all hospice providers serving SFHP members must provide timely notification to SFHP of member’s election of hospice services, recertification, facility-to-facility transfers, or revocation of hospice.

SFHP requires members receive hospice care from an in-network provider unless medically necessary services are not available in-network. Non-contracted Hospice providers should seek a Letter of Agreement (LOA) or single case agreement with SFHP in addition to the listed required documents.

| Scenario | Notification Timeframe | Required Documentation |
|---|------------------------|---|
| Initial Hospice Election | 5 Calendar days | <ul style="list-style-type: none"> • A copy of the certification of the member’s terminal condition; • A copy of the member’s signed election form; and • A copy of the written initial plan of care. |
| Recertification for Continued Hospice Care | 5 Calendar days | <ul style="list-style-type: none"> • Updated certification of terminal illness; • Updated plan of care; and • Documentation of Face-to-Face encounter (if applicable). |
| Inpatient Hospice Care (Requires Prior Authorization) | 24 hours | <ul style="list-style-type: none"> • A written prescription signed by the member’s attending physician; • Justification for the general inpatient care level of care; • A copy of the certification of the member’s terminal condition; • A copy of the written initial plan of care; and • A copy of the member’s signed election form. |
| Transfer between Hospice agencies | 5 Calendar Days | <ul style="list-style-type: none"> • Signed (by member or representative) written statement of change in designated hospice provider; and • Transfer summary including essential information regarding member’s diagnosis and plan of care. Must be signed by physician. |
| Member Revocation of Hospice | 5 Calendar days | <ul style="list-style-type: none"> • Signed written statement of revocation from member or representative. |

General Inpatient Hospice Care

Submit the prior authorization request by selecting:

1. Request Type: **Prior-Authorization**
2. Request Priority: **Expedited**
3. Reason for Request: **General Inpatient Hospice Care**
4. Place of Service
5. Code Type: HCPC or Revenue
6. Service Code: T2045 or 0656 (Rev)
7. Start Date & End Date
8. Requested # of Days (60 or 90)

Enter Requesting and Rendering Providers, add Fax and Phone Contact records using Requesting Provider as the Contact Type, attach supporting documents and enter relevant notes.

Click **Submit** to send the request to SFHP.

Outpatient Request

Episode Details

1 Request Type * Prior-Authorization

2 Request Priority * Expedited

Time Request 24 Hours

3 Reason for Request * General Inpatient Hospice Care

Service/Specialty Drug Request

Service Type * Authorization request via Provider Portal

Modifier

4 Place Of Service Nursing Facility

5 Code Type * HCPC

6 Service Code * T2045--Hospice general inpatient care

7 Start Date * 11/01/2025

End Date * 12/30/2025

8 Requested # * 60

[Advanced Search](#)

[Optional Fields](#)

Add

Other Hospice Care Notification

For routine, continuous care, or other notification types, submit the notification as follows:

1. Request Type: **Prior-Authorization**
2. Request Priority: **Routine**
3. Reason for Request: **Hospice Care - Other**
4. Place of Service
5. Code Type: HCPC or Revenue
6. Service Code(s): As applicable (0552, 0650, 0659, 0652, 0657, 0658)
7. Start Date & End Date
8. Requested # of Days (60 or 90)

Enter Requesting and Rendering Providers, add Fax and Phone Contact records using Requesting Provider as the Contact Type, attach supporting documents and enter relevant notes.

Click **Submit** to send the notification to SFHP.

Outpatient Request

Episode Details

1 Request Type *

Time Request

2 Request Priority *

3 Reason for Request *

Service/Specialty Drug Request

4 Service Type *

5 Place Of Service

6 Code Type *

7 Service Code *

[Advanced Search](#)

[Optional Fields](#)

Add

Modifier

8 Start Date *

End Date *

Requested # *

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