SAN FRANCISCO HEALTH PLAN
HOSPICE NOTIFICATION FORM

San Francisco Health Plan℠

HOSPICE CARE ELIGIBILITY

Individuals may be eligible for hospice care if they meet the following criteria:

- A physician certifies that the member has a life expectancy of six (6) months or less due to a terminal illness.
- The member (or their authorized representative) voluntarily elects hospice care by signing an election statement with a licensed hospice provider.

By electing hospice care, the member acknowledges the following:

- Hospice services are focused on comfort, pain relief, and emotional support, rather than curative treatment.
- Certain benefits related to the terminal condition are waived during the hospice election period.
- The member understands that hospice care is provided in lieu of standard coverage for services directly related to the terminal illness.

LEVELS OF HOSPICE CARE

- **Routine Home Care:** Standard hospice services provided in the member's home or residential setting. Includes nursing, social work, counseling, and aide services.
- **Continuous Home Care:** Time-limited, intensive nursing care provided during a crisis to manage acute symptoms at home. Must be provided for at least 8 hours in a 24-hour period.
- **Respite Care:** Short-term inpatient care provided to relieve family or caregivers. Typically limited to 5 consecutive days per occurrence.
- **General Inpatient Care:** Short-term inpatient care for pain control or symptom management that cannot be managed in other settings. Provided in a contracted facility.

NOTIFICATION REQUIREMENTS FOR HOSPICE PROVIDERS

- Hospice providers must notify SFHP within five (5) calendar days of both the certification of terminal illness and the member's election of hospice care.
- For general inpatient care placements that occur outside of normal business hours, notification must be submitted by the next business day.
- **Failure to provide timely notification to SFHP will result in denied claims.** SFHP may request additional documentation to ensure appropriateness of services and confirm that claims are accurate and not based on fraudulent or incomplete submissions.
- 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 below.
- **Submission Method:** Fax all notifications and documentation to SFHP at **1(415) 943-9711** or submit through the **SFHP Provider Portal**.
- If you have questions or need assistance with documentation requirements, please contact SFHP Utilization Management Department at **1(415) 547-7818** ext. **7080.**

Scenario	Notification Timeframe	Required Supporting Documentation
Initial Hospice Election	5 Calendar days	• Certification of the member's terminal condition; • Member's signed DHCS hospice election form; and • Written initial plan of care.
Recertification for Continued Hospice Care	5 Calendar days	• Updated Certification of Terminal Illness; • Updated Plan of Care; and • Documentation of Face-to-Face encounter (if applicable).
Inpatient Hospice Care	24 hours	• A written prescription signed by the member's attending physician; • Justification for the general inpatient care level of care; • Certification of the member's terminal condition; • Written initial plan of care; and • Member's signed DHCS hospice election form.
Transfer between Hospice agencies	5 Calendar Days	• 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	• Signed written statement of revocation from member or representative.

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NOTE: ALL FIELDS ARE REQUIRED.

TYPED ONLY - NO HANDWRITTEN FORMS

Benefit Period: ☐ First 90-day period ☐ Second 90-day period ☐ Subsequent 60-day period

Other Notification Type (If Applicable): ☐ Hospice Discharge ☐ Hospice Provider Transfer ☐ Member Revocation

Does member have other Primary coverage? ☐ Yes ☐ No If yes, specify carrier and policy #:

PATIENT INFORMATION	REQUESTING PROVIDER	
Name:	☐ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary	
SFHP ID#:	Provider Name:	
Date of Birth (MM/DD/YYYY):	NPI#:	Specialty:
Phone Number:	Phone Number:	Fax:
Address:	Contact Name:	
	Address:	

NETWORK	HOSPICE PROVIDER	
Out of Network? ☐ Yes (select reason) ☐ No	Name / Facility / Vendor:	
Out of Network Reason:	NPI#:	Specialty:
☐ Service not available in network ☐ Continuity of Care	Phone Number:	Fax:
☐ Second Opinion	Contact Name:	
☐ Other (describe):	Address:	

DIAGNOSES/HOSPICE SERVICE CODES

Diagnosis Codes (at least one code):

Place of Service: ☐ Skilled Nursing Facility ☐ Assisted Living/Independent Living ☐ Hospital ☐ Home

Name of Facility (if applicable):

Hospice Billing Codes: If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS values.

Code	Description	Units	Code	Description	Units
☐ 0552	Routine Home Care-Service Intensity Add-on Rate		☐ 0657	Physician Services	
☐ 0650	Routine Home Care – High Rate		☐ 0655	Inpatient Respite Care	
☐ 0659	Routine Home Care – Low Rate		☐ 0656/T2045	General Inpatient Care (Non-Respite)	
☐ 0652	Continuous Home Care		☐ 0658	Hospice Room and Board	

Hospice Election Date: **Today's Date:**

Comments:

Important: Please attach appropriate clinical documentation to support your hospice notification/request.

☐ Written order signed by attending physician ☐ DHCS Hospice Election Form (DHCS 8052) ☐ Initial Written Plan of Care

☐ Certification of Terminal Illness by physician ☐ Hospice Inpatient Info Sheet (DHS 6194) ☐ Face-to-Face encounter Verification

☐ Other: