

CHNCT HOSPICE INTAKE FORM

Member Name: _____ Date of Birth: _____

Member ID: Husky: _____ Charter Oak: _____

Contact Name: _____ Home Care Agency: _____

Phone: _____ Fax: _____

Ordering MD: _____

Please print the ordering physician's FULL name and address *clearly* as we *cannot* process your request without this important information!

Date of initial visit: _____ Diagnosis code: _____

Home Hospice: _____ Inpatient Non-Respite Hospice: _____

Inpatient Respite Hospice: _____ Private Duty Nursing Hospice: _____

Document Checklist:

- Certification of terminal illness
- W-406 Hospice Election Form signed by member
- 485 form (treatment plan)
- Signed MD orders
- Updated clinical information

Clinical notes including W-406 and 485 form or SIGNED MD orders must accompany fax request.

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF ALL CLINICAL INFORMATION TO PROCESS REQUEST****
