Hospice Care Eligibility Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Patient Name: [Patient's Name]

Patient ID: [Patient's ID]

Dear [Insurance Company Representative's Name],

I am writing to formally request eligibility for hospice care services for my patient, [Patient's Name], who has been diagnosed with a terminal illness. [He/She/They] is currently under my care and has a prognosis of six months or less to live.

Details of the patient's condition are as follows:

- Diagnosis: [Insert Diagnosis]
- Date of Diagnosis: [Insert Date]
- Current Treatment: [Insert Current Treatment]
- Relevant Medical History: [Insert Medical History]

Based on the above information, I believe that hospice care is appropriate and necessary for [Patient's Name] to ensure comfort, dignity, and quality of life during this critical time.

Please find attached the required medical documentation to support this request. I appreciate your prompt attention to this matter and look forward to your favorable response.

Thank you for your consideration.

Sincerely,

[Your Name]

[Your Title]

[Your Contact Information]

[Your Medical Practice/Organization]