Highmark Medicare Advantage
Advanced Illness Services (AIS) Quarterly Report

Hospice Name: **Report Period From:**

Name of Person Completing Report: **Phone Number:** **Email:**

Last Name	First Name	UMI#	DOB	Referral Source*	Place of Residence*	Date of AIS Enrollment	Date of Disenroll-ment*	# of Days in Program to Date	HCPOA or LW Completed*	POLST Completed Y or N

Legend

Please use the following codes for all measures indicated with *

Referral Source
1 = Physician
2 = Facility
3 = Highmark
4 = Other

Place of Residence
1= Patient's own residence
2 = Another party's residence
3 = Assisted living facility
4 = Other

Disenrollment reason
1 = Death
2 = Hospice enrollment
3 = Medical condition improved
4 = Dissatisfaction with AIS Services or provider
5 = Loss of eligible coverage

HCPOA or Living Will
1 = Completed prior to member's AIS enrollment, copy on file with MD
2 = Completed prior to member's AIS enrollment, copy not on file with MD
3 = Completed by AIS provider, copy on file with MD
4 = Completed by AIS provider, copy not on file with MD
5 = No HCPOA or LW completed

Please use this email address for question you may have associated with the program and to submit the quarterly reports: **AIS@Highmark.com** *Additional forms are located on the Provider Resource Center,* under *Clincal Reference Materials*.

Note: Cumulative quarterly report to include data on any Highmark Medicare Advantage plan member for whom services have been provided.

Check here if no activity this quarter._____

Report due to Highmark:

April 10th
July 10th
Oct. 10th
Jan 10th

Report may be sent via shared mailbox

Jun-12