MEDICARE REVOCATION / TRANSFER OF HOSPICE BENEFIT

Patient Name: ____ MR#: ________________

Address: ____

Medicare #: ______________________ Social Security No:_______________________________

I, ____, desire to voluntarily revoke / transfer the election (Patient/Primary Care Giver)

of Hospice care being provided for ____.
(Name of Patient)

This Revocation / Transfer shall be effective as of ____/____/____.

☐ (Check here for Revocation)
I understand that upon revocation of the hospice benefit for this particular election period, there will no longer be coverage for hospice, and that coverage of benefits that were waived at the time of hospice election will resume. When revocation occurs before an election ends, the remaining days for that period will be lost. I also understand that I may at anytime reelect to receive hospice services, if I meet admission criteria.

OR

☐ (Check here for Transfer)
I understand that I am choosing to transfer from:

____to: ______________________________________
(Current Hospice Provider)(New Hospice Provider)

to receive hospice services under my Medicare hospice benefit.

I have been given opportunity to discuss the terms of this statement with a hospice representative and I fully understand the terms of this statement.

I, therefore, revoke / transfer the hospice benefit due to:

____

____

____ ______________________________
Signature of Patient/Primary Care Giver Date

____ ______________________________
Signature of Hospice Representative Date

Created:
Updated: