Center for Hospice Care
choices to make the most of life™

NOTICE OF ELECTION OF HOSPICE BENEFIT

I (*patient name*), _____ **DOB:** _____

choose to elect the ☐Medicare, ☐Commercial, ☐ Self pay hospice benefit from Center for Hospice Care, ☐ Medicaid.

I understand the purpose of hospice care and that the treatment is primarily palliative rather than curative. I understand that the goal of hospice care is not to cure my terminal illness, but to maintain my quality of life through palliative and supportive care and management of symptoms. Medicare patients: Certain Medicare services are waived when the Medicare Hospice benefit is elected and this has been fully explained to me.

Initial:

_____ I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor, volunteer and other disciplines that may be necessary.

_____ I understand that I can revoke this benefit at any time and resume regular **Medicare** coverage. I know I will lose any hospice days remaining in the benefit period in which I revoke.

_____ I understand that I may transfer my **Medicare** hospice care to another hospice program once during each election period.

Initial:

_____ I understand I have the right to choose an attending physician, who may be a physician or nurse practitioner. I understand I am not required to have an attending to elect my benefit and Center for Hospice Care Hospice Physicians/Nurse Practitioners (NP) will serve as my attending. I also understand in the event my elected physician is unable or chooses not to attend, Center for Hospice Care Hospice Physicians/Nurse Practitioners can serve as my attending or I can choose another physician. I understand I have the right to change my attending at any time by completing a form provided by Center for Hospice Care.

☐ I do have an Attending Physician/Nurse Practitioner *(print full name)*:_____

☐ If my attending physician is unavailable or I do not have a physician, I choose the CHC Hospice Physician/NP*(print full name*):

_____

_____ _____
Beneficiary or Representative Signature Date

_____
Relationship of Legal Representative to Beneficiary

_____ _____
Agency Representative Signature Date

CHC Use Only

Benefit Period: ☐ First 90 ☐ Second 90 ☐ Unlimited 60

Attending NPI:_____ Address: _____

CHC MD/ DO/NP NPI# _____

Effective Date of Hospice Election: _____ **ICD-10:** _____