

Effective _____
(Date of Revocation)I _____ DOB: _____
(Print Patient's Name)

Choose to revoke my election of the Hospice Medicare Benefit and acknowledge the following:

1. I may at any time in the future re-elect hospice coverage—beginning with the next benefit period, if I still qualify.
2. The Medicare coverage I waived to receive hospice benefits will be resumed immediately, if I still qualify.

Patient/Patient Representative Signature_____
Date_____
CHC Employee_____
Date

*Revised 8/2016
Nursing/Revocation form*