Center for Hospice Care

# Hospice Medicare Benefit
# Revocation Form

Effective _____, I _____,
(date of revocation) (patient's name)

choose to revoke my election for the Hospice Medicare Benefit.

1. I am revoking for the following reason:

   _____

   _____

   I may at any time in the future re-elect Hospice Medicare Benefit coverage, if I qualify, beginning with the next benefit period.

2. I understand that the Medicare coverage I waived to receive hospice benefits will be resumed immediately if I still qualify.

_____ _____
Patient/Patient Representative Signature Date

*Revised 3/00*
*Nursing/Revocation form*

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