

NOTICE OF ELECTION OF HOSPICE BENEFIT

I (patient name), _

DOB:

choose to elect the \Box Medicare, \Box Commercial, \Box Self-pay hospice benefit from Center for Hospice Care.

Start of Care date: ___

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

<u>Initial:</u>

_____ I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand the palliative rather than curative nature of hospice care, as it relates to my terminal illness and related conditions.

_____ I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.

_____ I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and hospice should cover all care related to my terminal illness and related conditions needed under the hospice election.

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions. If my attending chooses not to attend, the attending will default to a Center for Hospice Care Physician or Nurse Practitioner.

□ I do have an Attending Physician/Nurse Practitioner (print full name):______

□ If my Attending Physician is unavailable, I choose a CHC Hospice Physician or Nurse Practitioner.

□ I would like to request my Attending Physician to be a CHC Hospice Physician or Nurse Practitioner.

Beneficiary or Representative Signature	Relationship	Date
Print Name	_	
□ Beneficiary is unable to sign -Reason:		
Agency Representative Signature	Date	



NOTICE OF ELECTION **OF HOSPICE BENEFIT**

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Right to Immediate Advocacy:

As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QID) to request for Immediate Advocacy if you (or your representative) disagree with decision of hospice agency or items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions. Please call your QIO for an appeal or guestions: Livanta (888) 524-9900.

Right to Request Medicare "Patient Notification of Hospice Non-Covered Items, Services, and Drugs:

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- If you provide written notification within 5 days of your hospice election, Center for Hospice Care must provide this form to you within 5 days of your request. If you provide written request for this from at any point after the first 5 days of the start date of hospice care, Center for Hospice Care must provide this form within 3 days of your request.

Patient/Family received information on the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs.

Patient/family signature: Date:

Unable to obtain signature for "Patient Notification of Hospice Non-Covered Items, Services, and Drugs due to:

Agency signature: _____ Date:

CHC Use Only:		
CHC MD/DO/NP NPI: Address:	Attending NPI:	