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

Revocation of Hospice Medicare Benefit

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

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