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.

Effective Date of Election: _____________

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.

Initial:

_____ 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 acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

☐ I **elect** to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."
Initials_______ Date________

☐ I **decline** to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"
Initials________ Date________

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

☐ Beneficiary is unable to sign -Reason: ____

____ ___________________________
Agency Representative Signature Date

CHC Use Only:

CHC MD/DO/NP NPI: ___________________ Attending NPI: ______________________

Address: ______________________________

Revised 07/2021
Billing/NOE Hospice Benefit