HOSPICE & HOMECARE OF RENO COUNTY

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Transfer of Hospice Agency or Revocation of Hospice Services

Patient Name: _____ **Address:** _____ **Medicare Number:** _____ **Medicaid Number:** _____ **Private Insurance:** _____	**Benefit Period:** **O 1st 90 Day Period** **O 2nd 90 Day Period** **O 60 Day Period** **#:**_____	**Status Change:** **O Revocation of Hospice Services** **O Change/Transfer of Hospice Provider**

Revocation of Hospice Services:

Effective _____, I choose to no longer receive hospice services.
(Date)

If I am a Medicare Beneficiary, I understand:

I understand I am revoking the hospice benefit period. In doing this, I am forfeiting hospice coverage for the remaining days in that election period.

I understand that the health care benefits I waived to receive hospice coverage will automatically be resumed effective the date of this revocation.

I understand I can re-enroll in hospice coverage at any time in the future that I am determined to be eligible for services.

Change/Transfer of Hospice Provider:

Effective _____, I choose to no longer receive hospice services from
(Date)

_____ and choose to transfer care to
(Current Provider)

_____.
(New Provider)

If I am a Medicare Beneficiary, I understand:

I understand that changing to another hospice program will not cause a loss of benefit days. I may change hospices only once in each benefit period.

Patient/Representative Signature: _____ Date: _____

Relationship to Patient: _____

Hospice Staff Signature: _____ Date: _____