

Medicare Hospice Election Statement

Draft Sample

I, _____ choose to elect the Medicare hospice benefit and receive
(Beneficiary Name)
Hospice services from _____
(Hospice Agency)

Hospice Philosophy

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.

Effects of a Medicare Hospice Election

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.

Right to choose an attending physician

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.

[] I do not wish to choose an attending physician

I acknowledge that my choice for an attending physician is:

Physician Full name: _____ NPI (if known) _____

Office Address: _____

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by

_____ to begin on _____
(Hospice Agency) (Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Signature of Beneficiary/Representative _____

(Date) _____

[] Beneficiary is unable to sign -

Reason: _____

Witness signature _____

(Date) _____

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.