island health care island hospice independent life at home ideal aging

# MEDICARE HOSPICE BENEFIT REVOCATION

_______________________________________________ ___________________

Patient Name Date

_______________________________________________________________________________________________

Insurance Name and Number

I am requesting revocation of my election for Medicare coverage of hospice care for this benefit period, initiated __________________________________________.

Date of Election

I understand that in doing so, I forfeit the remainder of the benefit and upon re-admission will enter a new benefit period.

- I acknowledge that the remainder of the benefit period currently being utilized is hereby waived.

  ☐ 1st 90 days ☐ 4th (60 days)
  ☐ 2nd (90 days) ☐ 5th (60 days)
  ☐ 3rd (60 days) ☐ ___ (60 days)

- I understand that the revocation will be effective on __________________________________________.

  Date of Revocation

- In understand that my Medicare coverage for those benefits previously waived will resume.

- I also understand that I may again elect the Medicare Hospice Benefit at any time as long as my condition warrants Medicare Hospice care.

_______________________________________________ ___________________

Patient's Signature Date

_______________________________________________ ___________________

Legal Guardian Signature Date

_______________________________________________ ___________________

Witness/Agency Representative Signature Date

☐ Patient unable to sign due to: _________________________________________________________________

Comments: ____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________