

**HOSPICE & COMMUNITY CARE**

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(717) 295-3900

FAX: Administration (717) 391-9582**Inpatient Center (717) 735-9674****Homecare (717) 391-9573****TO: BILLING DEPARTMENT****FACILITY NAME:** _____**FAX #:** _____ **DATE:** _____**RE: NURSING HOME BILLING ARRANGEMENTS****Patient:** _____ **DOB:** _____ **SSN:** XXX-XX-**_____ I. ELECTION OF HOSPICE MEDICARE/MEDICAID BENEFIT**

Effective Date: _____ Hospice Diagnosis: _____

Bill Hospice & Community Care for:

- Medical supplies
- Medical equipment
- Medications related to the hospice diagnosis (provided/billed via contractual relationship with Health Direct Pharmacy Services/Williams Apothecary or Wellspan Pharmacy)
- Other services related to the hospice diagnosis

_____ II. NON-ELECTION/REVOCATION OF HOSPICE MEDICARE/MEDICAID BENEFIT

Effective Date: _____ Hospice Diagnosis: _____

- Hospice is not billed for any services or supplies from facility.
- Hospice and patient have a direct agreement for Hospice support.

_____ III. CHANGE IN HOSPICE DIAGNOSIS

Effective Date: _____ New Hospice Diagnosis: _____

_____ IV. HOSPICE RESPITE

Beginning Date: _____ Ending Date: _____

Bill Hospice & Community Care for:

- Contractual rate for room and board
- Medical supplies
- Medical equipment
- Medications related to the hospice diagnosis (provided/billed via contractual relationship with Health Direct Pharmacy Services/Williams Apothecary or Wellspan Pharmacy)
- Other services related to the hospice diagnosis

_____ V. OTHER**Please contact _____ at _____ with questions**

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