HOSPICE & COMMUNITY CARE
A Program of Choices Healthcare
877-506-0149

685 Good Drive
P. O. Box 4125
Lancaster, PA 17604-4125
Provider Number: 39-1515

Patient Name: _____

MRN: _____

ELECTION OF HOSPICE MEDICARE BENEFIT-INFORMED CONSENT

I ACKNOWLEDGE/UNDERSTAND THE FOLLOWING:

I understand the nature of the hospice care available through the Hospice Medicare Benefit and am aware that all services will be comprehensive, holistic and palliative in nature rather than curative. Items, services and medications will be for management of symptoms and to provide comfort for my terminal illness and related conditions, along with support for me and my family/caregivers.

I understand there will be a hospice team providing care for me composed of a physician, nurse, social worker, pastoral counselor, volunteer and other disciplines that may be necessary.

While I am receiving hospice benefits I waive the right to all other Medicare benefits related to my terminal illness and related conditions under the Medicare Program.

Only Hospice & Community Care, a program of Choices Healthcare will be able to receive Medicare payment for care or services provided to me for my terminal illness and related conditions.

Medicare or other insurance does not necessarily cover all items, services and drugs. Although it would be rare, there could be some necessary items, drugs or services that will not be covered by the hospice because Hospice has determined that these items, drugs or services are to treat a condition that is unrelated to the terminal illness or related conditions. It has been explained and I understand that I or my representative have the right to ask for an election statement addendum, the **Patient Notification of Non-Covered Items, Services and Drugs,** at time of admission or anytime throughout care. This addendum will include items, services and drugs that Hospice has determined to be unrelated to my terminal illness and related conditions and will not be paid by Hospice.

Some items, services or drugs may be related to the terminal illness or related conditions but no longer be medically appropriate. Hospice will alert me to these items, if they occur, and discontinue them from the hospice plan of care. If I choose to continue with these items, I will be financially responsible for them.

I understand that I can use standard Medicare in the usual manner to pay the bill of:

1. My doctor, if he is not an employee of this hospice.
2. Treatment of a condition unrelated to the illness and related conditions for which I am using Hospice care.

I understand Hospice service may be discontinued at any time through the revocation or discharge process and regular Medicare coverage will resume.

I understand that I have the right to immediate advocacy through the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), LIVANTA at 1-888 396-4646, TTY 1-888-985-2660.

I ACKNOWLEDGE RECEIPT OF WRITTEN INFORMATION ON MEDICARE HOSPICE BENEFIT.

ACKNOWLEDGING/UNDERSTANDING THE ABOVE, I AUTHORIZE HOSPICE MEDICARE COVERAGE.

Effective Date for the Medicare Hospice Benefit: _____
(Month/Day/Year)

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DESIGNATION OF ATTENDING PHYSICIAN

The ***attending physician*** is:

- A doctor of medicine or osteopathy, or a nurse practitioner or physician assistant;
- Chosen by the patient (or representative) at the time he or she elects to receive hospice care;
- Has the most significant role in the determination and delivery of the patient's medical care.

☐ Attending physician chosen by patient (or representative) if available and willing: _____

_____
(*Please print full name*)

Office Address: _____

_____

☐ NO attending physician identified. Palliative Medicine Consultants to manage medical care.

_____ _____ _____
(Patient/Representative) (Print Name) *(Signature of Patient/Representative)* *(Date)*

NOTE: If someone other than the patient signs: _____
(Reason the patient cannot sign)

_____ _____ _____
(Hospice Representative) (Print Name) *(Signature of Hospice Representative)* *(Date)*

For Staff Use Only

Reviewed purpose and availability of election addendum now and during course of care Yes____

Patient/representative requests addendum: Yes ___ No ___

Preferred method of delivery of addendum:

in person ___ US mail ___ email ___ address: _____

Inform patient/representative that if addendum requested, a signature within 5 days of admission is required.

Complete Addendum Request form in Suncoast