



Hospice Benefit Election Form

I, _____ have been informed about the hospice benefit provided for those with a terminal illness.

By signing below, I acknowledge and understand the following:

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 acknowledging that I understand the palliative rather than curative nature of hospice care, as it related to my terminal illness and related conditions. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (giving 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; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and hospice should cover all care related to my terminal illness and related conditions needed under the hospice election.

ACKNOWLEDGMENT OF COVERAGE AND LIMITATIONS

I understand that the hospice benefit is divided into benefit periods. The first two benefit periods are 90 days followed by an unlimited number of 60-day benefit periods (private insurance may have different limits, depending upon the policy). I understand that I may use these periods as long as my condition warrants hospice care.

I understand that for the duration of the election of hospice care, I waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
- Any Medicare services that are related to the treatment of my terminal illness or related conditions for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:
 - Provided by my designated hospice;
 - Provided by another hospice under arrangements made by my designated hospice; and
 - Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

An election to receive hospice care will be considered to continue through the initial election period and through subsequent election periods without a break in care as long as the individual remains in the care of a hospice, does not revoke the election benefit, and is not discharged from the hospice.

Print Patient Name: _____ MR#: _____



REVOCAION OF HOSPICE BENEFITS

If I choose to, I may revoke my election of hospice care at any time during an election period. To revoke the election of hospice care, I must file a statement with the hospice that includes the following information:

- A signed statement that I revoke my election for Medicare coverage of hospice care for the remainder of that election period.
- The date that the revocation is to be effective. I may not designate an effective date earlier than the date that the revocation is made.

Re-Election of hospice benefits: If an election has been revoked, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with Medicare regulations, for any other election period(s) that is still available to the individual.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations. The contact information for the BFCC-QIO in Oregon is KEPRO (888) 305-6759 (toll-free) (813) 280-8256 (local) (855) 843-4776 (TTY) or www.keproqio.com.

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 BeLoved Hospice, Inc. 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 hereby elect BeLoved Hospice, Inc. as my only provider of Hospice services and authorize BeLoved Hospice, Inc. to bill my insurance plan(s). I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to BeLoved Hospice, Inc.. I agree to pay applicable co-pays in a timely manner.

My primary insurance is: Medicare # _____ My election shall be effective on: ___/___/_____

Medicaid # _____ Private Insurance: _____

Patient or Representative Signature: _____ Date: ___/___/_____

Indicate relationship, if signed by the patient's representative: _____

Reason patient unable to sign: _____

Print Patient Name: _____ MR#: _____

