Hospice Election Statement

AGERIGHT ADVANTAGE

Please ensure to complete this form in its entirety.

Member Name: _____

Member ID #: _____

Hospice Philosophy

I acknowledge that I have been given a full explanation and understand 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.

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 and I have been provided with the contact information for the BFCC-QIO that services my area.

☐ I elect to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Initials _____ Date _____

(Hospice: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☐ I decline to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Initials _____ Date _____

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 Signed)

☐ Beneficiary is unable to sign -Reason:

_____

_____ _____

Witness signature (Date Signed)

Please Scan and email this form to HospiceNOE@allyalign.com