ATTENDING PHYSICIAN CHANGE NOTICE
FOR MEDICARE HOSPICE BENEFIT
Rev 04/19

As of this date: ______________, I ________________________________
(Patient’s Name)
elect to change my attending physician:

From: __________________________ NPI: __________________________
(Name of Attending Physician) (Provider Number)
(Address, City/State)

To: __________________________ NPI: __________________________
(Name of Attending Physician) (Provider Number)
(Address, City/State)

Signed:

A. Patient or Authorized Representative:

______________________________ Date: ________________
(Name) ________________________________

B. High Peaks Hospice Representative:

______________________________ Date: ________________
(Name/Title) ________________________________

Copy sent to: Former Attending Physician on (Date): ________________
Current Attending Physician on (Date): ________________

Fax to Billing Office Date: ________________

Original to Patient File