Election of Medicare Hospice Benefit
Rev 04/19

I, (Print Name)_______________________________, elect to receive care under the Medicare Hospice Benefit provided by High Peaks Hospice (HPH) starting on _______________________.

I choose ________________________________ (First and Last Name of Attending Physician) to be my attending physician while on HPH services. I understand I can change my attending physician at any time by doing so in writing. I fully understand that the goal of hospice care is to support quality of life, reduce symptoms and provide support for physical, emotional and spiritual issues as they relate to the terminal illness. HPH does not provide curative care.

I ALSO UNDERSTAND THE FOLLOWING:
1. By electing the Medicare Hospice Benefit I waive my rights to Medicare payments for the duration of the election for the following services:
   a. Hospice care provided by a hospice other than High Peaks Hospice (HPH)
   b. Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or related conditions or that are equivalent to hospice care except for services:
      i. provided by HPH or another hospice under arrangements made by HPH
      ii. provided by my attending physician, if this physician is not an employee of HPH or receiving compensation from HPH for those services.
2. Services that are not related to the terminal condition may still be covered by traditional Medicare.
3. The Medicare Hospice Benefit consists of two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.
   a. Eligibility for continued hospice care is determined prior to the beginning of each benefit period. Before the 3rd benefit period can start a face-to-face visit must be made by HPH staff.
   b. Hospice care will continue through the benefit periods without a break as long as I remain in the care and service area of HPH and remain eligible for hospice services.
4. If I seek care for my terminal illness, beyond what is considered medically necessary by the HPH interdisciplinary team (IDT) and documented on my plan of care, I am responsible for the cost of that care.
5. I can choose to leave hospice care at any time and return to my regular Medicare plan benefits by completing a dated revocation form. I understand that if I revoke my Medicare Hospice Benefit in the middle of a benefit period, I give up only the remaining days of that benefit period. I also understand that at any time I may re-elect to receive hospice services for any other benefit periods that I am eligible to receive.

I have read or had read to me this election form and have had all my questions answered. I acknowledge the designated Attending Physician is my choice.

Signature of Patient or Authorized Representative _______________________ Date__________
Relationship (if not Patient Signing) _________________________________ TIME: ___________ AM/PM
Signature of Witness/Relationship _________________________________ Date ____________

Policy: Determining Medicare Hospice Eligibility CP218