Hospice of Warren County
2 Crescent Park West, P.O. Box 68, Warren PA 16365
Phone: (814) 723-2455 Fax: (814) 723-6259

PATIENT'S NAME_____

HOSPICE OF WARREN COUNTY
2 CRESCENT PARK WEST
WARREN, PA 16365
PROVIDER NO. 39-1551

MEDICARE HOSPICE BENEFIT REVOCATION

As a Medicare Hospice beneficiary, I wish to revoke the election of Medicare coverage of hospice care for the remainder of benefit period #_____.

I understand that I am forfeiting the right to _____ days of hospice coverage in the current benefit period. Should I choose to re-elect the Medicare Hospice benefit at a later time, I retain the right to use _____ days in benefit period #_____, and, if applicable, unlimited 60 day benefit periods.

THE BENEFIT PERIODS ARE AS FOLLOWS:

FIRST BENEFIT PERIOD – 90 DAYS
SECOND BENEFIT PERIOD – 90 DAYS
UNLIMITED 60 DAYS
****

I DIRECT THIS REVOCATION TO BE EFFECTIVE ON _____ _____
DATE TIME am / pm

I UNDERSTAND THAT THE MEDICARE HEALTH CARE BENEFITS WHICH I WAIVED TO RECEIVE HOSPICE MEDICARE COVERAGE WILL BE RESUMED ON THE ABOVE DESIGNATED DATE.

_____ _____
SIGNATURE OF BENEFICIARY OR LEGAL REPRESENTATIVE DATE

_____
RELATIONSHIP OF LEGAL REPRESENTATIVE TO BENEFICIARY

_____ _____
WITNESS SIGNATURE DATE

*** Hospice Revocation cannot be effective prior to the date this form is signed. A beneficiary may designate the effective date to be the same date as the signature date or a date in the future.