

Model Example of Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from _____ (Name of Hospice Agency) to begin on _____ (Start of Care Date).

(Note: The start of care date, also known as the effective date of the election, 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.)

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:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of 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.
- I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means 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 items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

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Your Addendum: “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”

- As a Medicare beneficiary who elects to receive hospice care, your hospice must provide you (or your representative), in writing, the “**Patient Notification of Hospice Non-Covered Items, Services, and Drugs**” addendum (and any updates) that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish the written addendum within 5 days of the election start date. If there are any changes to your plan of care during the course of hospice care that impact the lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice, the hospice must furnish this written addendum update within 3 days.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice’s determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: _____

BFCC-QIO Phone Number or Website: _____

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____