HOSPICE BENEFIT ELECTION STATEMENT

PATIENT NAME: (please print) **MR #**

I choose admission to Gulfside Hospice & Pasco Palliative Care (GHPPC) and elect Hospice to provide for my care. I understand hospice care is palliative in nature rather than curative as is relates to my terminal illness.

I understand the hospice will submit claims under my insurance benefit for payment and treatment of services for my terminal illness. I acknowledge that I have been given the right to chose Dr._____as my attending physician.

_____ (Initials) In the event above named physician is unable to be reached, the hospice physician will assume my care. If I require general in-patient level of care, GHPPC physicians will mange my care and provide for an ongoing sharing of information with above named attending physician for services both related and unrelated to my terminal illness.

INSURANCE COVERAGE (please choose one) ◯ Medicare ◯ Medicaid ◯ VA Benefit ◯ Commercial ◯ Other_____

I hereby authorize payment be made on my behalf directly to the Hospice for health insurance benefits otherwise payable to me for the professional or medical expense benefits allowable under my current insurance policy.

This is a direct assignment of my rights and benefits under this policy. I understand I may be responsible to the Hospice for any balance of service charges over and above this insurance payment.

- ☐ I may change hospices only once during the benefit period without losing any benefit days.
- ☐ I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary and is not part of the hospice plan of care.
- ☐ If I am eligible for Medicare or Medicaid hospice benefits, all related costs will be paid and I will have no financial obligation.
- ☐If I am not eligible for Medicare or Medicaid hospice benefits, but I have hospice benefits under a commercial medical insurance policy, I will be responsible for all or a portion of those costs not paid under the policy, i.e., deductibles, co-payments, and costs that exceed policy limits. The actual amount of these costs for which I am responsible will be determined based on a personal assessment of my finances and/or my family's finances.
- ☐Insurance plans other than Medicare or Medicaid may define other coverage limits for my terminal illness.
- ☐If I am not eligible for Medicare or Medicaid hospice benefits and I have no commercial insurance coverage, I may be responsible for all or a portion of the cost for hospice services based on a financial assessment to be performed on me and/or my family.

I understand if I am accepting the Medicare A Hospice Benefit, I waive my rights to regular Medicare B benefits except for the payments to (1) my attending physician and (2) treatment for medical conditions unrelated to my terminal illness.

I understand I may revoke the Hospice Benefit at any time. This revocation of hospice benefit must be in writing. All previously held insurance benefits are fully restored. The election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care.

MEDICARE SECONDARY PAYOR ONLY QUESTIONNAIRE

1. Are you currently working full or part-time? ☐ Yes ☐ No Is your spouse working full or part-time? ☐ Yes ☐ No
2. Are you entitled to Black Lung medical benefits? ☐ Yes ☐ No
3. Was this service for treatment of a work related injury or illness? ☐ Yes ☐ No

If YES, please provide the name and address of worker's comp agency, insurance company, and your employer.

4. Is this service for treatment of an illness or injury, which resulted from an automobile or other accident? ☐ Yes ☐ No

If YES, please provide the name/address and policy number of the auto or non-auto liability or no-fault insurer.

5. Do you have a fee service card from the Department of VA Affairs? ☐ Yes ☐ No

---

I elect my hospice benefit and authorize hospice services to be effective on: _____/_____/_____ (start of care date)
Date

Patient signed consents: ☐Yes ☐**No** **If No, specify why**_____

Date	Patient or Representative Print	Signature	Relationship

Date	Hospice Representative Print	Signature	Title