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# HOSPICE BENEFIT ELECTION FORM

CHAMPUS

MEDICARE

MR#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Team: \_\_\_\_\_

I, \_\_\_\_\_, choose to receive hospice care from Hope Hospice. I understand care and services provided by Hope Hospice are not to cure but to provide palliation which serves to alleviate symptoms of the terminal illness. Acknowledging and understanding, I authorize coverage at Hope Hospice and Palliative Care to begin on \_\_\_\_/\_\_\_\_/\_\_\_\_. I acknowledge and understand the following:

1. After choosing the Medicare/Champus Hospice Benefit, I understand that my regular Medicare part A&B coverage will not be active for care related to my life-limiting illness. Only Hope Hospice will receive payment from Medicare/Champus for care or services provided to me for my life-limiting illness or any condition related to that illness and within the hospice plan of care. I understand I must seek pre-approval for all care and services outside the hospice plan of care.

For all services provided, (i.e., outpatient, testing, pharmacy, equipment, hospitalization, etc.,) I understand I must utilize Hope Hospice contracted agencies.

- A. My attending physician will continue to receive payment from regular Medicare/Champus for services provided to me.
- B. Services not related to this illness will be paid by my regular Medicare/Champus coverage.
- C. Hope Hospice will be responsible for hospitalizations that are pre-authorized by Hope Hospice and related to the terminal illness. Hope Hospice must have a contract with the hospital for approval to be given. I understand that if I enter a hospital with which Hope Hospice does not have a contract, I must revoke my hospice benefit in order for regular Medicare/Champus to pay for hospitalizations related to my life-limiting illness and will be responsible for any payment related to the services received.

2. Medicare/Champus hospice services are divided into benefit periods. The periods are as follows: first benefit period-90 days; second benefit period-90 days; unlimited number of 60-day periods. This election is continuous through the benefit periods as long as my medical condition remains hospice appropriate. Hospice is responsible for reviewing my medical condition on an ongoing basis.

- A. If my physician or the hospice physician determines that my condition is no longer hospice appropriate, I will no longer be eligible for the hospice benefit.
- B. Hospice will inform me prior to any change in my care and assist with the planning for my needs.

3. I can choose to discontinue hospice care at any time by completing the program's revocation statement. I understand that if I cancel my benefit, I will then forfeit any days remaining in that benefit period. For example, if in the first benefit period, I cancel my hospice Medicare/Champus benefit after the first 10 days, I will give up the remaining 80 days in that benefit period.

4. I can choose to transfer to another hospice program once during each of the benefit periods. I must inform Hope Hospice of my wishes so that arrangements for transfer can be made. No benefit days will be lost by changing to another hospice program.

5. I give my consent for medical review personnel to conduct home visits with me and/or my family members in order to ensure that quality care is provided and that Medicare/Champus payments for the services received are appropriate. Refusal to permit entry into my home after consent is given will not affect care or payment for hospice services.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date