Medicare/Medicaid/Private Insurance

HOSPICE BENEFIT ELECTION FORM

PROVIDENCE
Hospice of Seattle

Patient Name: _____ DOB: _____ MRN: _____

Medicare/Medicaid:

- I understand that while this election is in force, Medicare/Medicaid will make payments for care related to my Hospice diagnosis to Providence Hospice. Services related to this diagnosis provided by other health care providers will not be reimbursed by Medicare/Medicaid unless specifically ordered and authorized by Hospice. Choosing Hospice care means I have given up the right to standard Medicare/Medicaid benefits for the treatment of this diagnosis. Medicare/Medicaid pays the entire cost of the covered services required to manage this diagnosis. Services NOT related to this diagnosis continue to be covered by Medicare/Medicaid in the regular fashion.
- I waive my rights to Medicare/Medicaid benefits related to my terminal diagnosis while enrolled in the Medicare/Medicaid hospice program.
- I may revoke this election at any time and thereby restore my Medicare/Medicaid benefits.
- While treatment to control pain and symptoms related to my hospice diagnosis are covered by hospice, any other treatment such as, hospitalizations, diagnostics or chemo, must be pre-approved by Providence Hospice (name).
- I understand that the Hospice program is palliative, not curative. The goals and program emphasis are on providing comfort and relief of symptoms.

Private Insurance:

- If I have coverage through a private insurance plan, service will be provided as detailed in the hospice financial disclosure form.
- I assign to the Providence Hospice any insurance benefits to which I am entitled from any insurance company or third party payor for the services provided to me. I request that payment of authorized benefits be made on my behalf directly to the agency.
- I understand that I am financially responsible for charges not paid by insurance or third party payors, except where program requirements or contractual agreements hold me harmless, for example, Medicare, Medicaid or insurance company contractual agreements.

Attending Physician:

I have chosen the following physician as my attending physician/ ARNP: _____.

PHYSICIAN/ARNP NPI #: _____

Acknowledging and understanding the above, I elect the Medicare/Medicaid/private insurance hospice benefit to be provided by Providence Hospice of Seattle beginning _____.

Client/Legal Representative Signature _____ Date _____

Printed name _____ Relationship to client _____

Witness Signature _____ Date _____