HOSPICE MEDICARE BENEFIT ELECTION FORM

Tidewell® SINCE 1980
YOUR LOCAL, NOT-FOR-PROFIT HOSPICE
www.tidewell.org

(PLEASE PRINT)

PATIENT'S NAME	MEDICARE CARD NUMBER

I choose to receive hospice care from Tidewell Hospice.

I acknowledge the following:

1. Supportive palliative care, rather than curative care, is provided by Tidewell. Tidewell's goal is to reduce pain and other symptoms and to provide emotional and spiritual support.
2. All care is physician directed through my attending physician ______________________________
3. By choosing Hospice Medicare benefits, you are forfeiting payment for other Medicare coverage. Only Tidewell Hospice will be able to receive Medicare payment for care or services provided relative to your terminal illness.
   a. Medicare will pay your attending physician as it always has if your physician is not a Tidewell employee or is not receiving payment from Tidewell.
   b. Services not related to your terminal illness will be covered by traditional Medicare.
4. The Hospice Medicare Benefit consists of two 90-day benefit periods and an unlimited number of subsequent 60-day benefit periods.
5. You can choose not to continue Tidewell care at any time by completing a revocation statement.
6. Should you secure care outside the Tidewell plan of care or without the involvement of Tidewell Hospice, you revoke hospice benefits and assume liability for those services.
7. To transfer to another hospice Medicare program, you must first confirm availability of service and acceptance. Tidewell Hospice must be notified of your wishes to allow for coordination of the transfer.

I hereby authorize the release of information and appropriate medical records to or from any hospice, skilled nursing facility, hospital, home health agency or private physician. I also authorize release of pertinent medical information to any source of third party reimbursement.

Acknowledging the above, I authorize hospice Medicare coverage from Tidewell Hospice

to begin on ______________________
(Month/Day/Year)

Date of signature *(must not post date the above date)*	Signature of patient or legal representative	Relationship
Date	Witness	Relationship

If patient is unable to sign, state reason: ______________________________

WHITE - CHART | YELLOW - PATIENT
CLIN025 06/09