

# REVOCAION OF BENEFIT ELECTION

(PLEASE PRINT)

<b>PATIENT NAME :</b>	<b>PATIENT NUMBER</b>
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I hereby request discontinuation of hospice Medicare services from TideWell Hospice.

I understand that I forfeit any further Medicare reimbursed hospice services in the remainder of this election period. This revocation of election of TideWell is effective as of the date signed below.

I understand that my traditional Medicare benefits resume immediately. I can elect at any time to receive hospice Medicare benefits for any of the election periods for which I am eligible with the consent of my attending physician and the TideWell Interdisciplinary Team.

\_\_\_\_\_  
Patient or Legal Representative Relationship Date

\_\_\_\_\_  
Witness Relationship Date

### Explanation:

- Admitted Skilled Nursing Facility
- Admitted Inpatient Unit No Contract
- Admitted Inpatient Unit Contrary to IDT Plan
- Admitted Inpatient Unit for Aggressive Therapy
- Admitted Home Health Agency
- Transfer to Noncertified Hospice (effective date) \_\_\_\_\_
- Other (please explain) \_\_\_\_\_

If patient is unable to sign, state reason: \_\_\_\_\_

\_\_\_\_\_

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