Doctor's Hospice of Idaho

Hospice Election Statement

I, _____ choose to elect the Medicare hospice benefit and receive
(Beneficiary Name)
Hospice services from Doctors Hospice of Idaho, LLC.

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicare Hospice Election

I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare.

Right to choose an attending physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician

I acknowledge that my choice for an attending physician is:
Physician Full name: _____NPI (if known) _____

Office Address: _____

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by

DOCTOR'S HOSPICE OF IDAHO, LLC , services to begin on _____
(Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

_____ _____
Signature of Beneficiary/Representative (Date)

☐ Beneficiary is unable to sign -
Reason:_____

_____ _____
Witness signature (Date)