



DATE OF ADMISSION: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

TRANSFER/CHANGE OF DESIGNATED HOSPICE PROVIDER: Effective date _____

I hereby choose to transfer my Medicare Hospice Benefit

From : _____ (current hospice)

_____ (City & State)

_____ (Phone number)

To : _____ (following hospice)

_____ (City & State)

_____ (Phone number)

I understand that, under MEDICARE, changing to another MEDICARE-certified hospice program once in each benefit period does not result in the loss of any Benefit days. I hereby authorize the release of medical information to the above-named hospice.

Signature of Patient or Patient's Representative/Date: _____