**FAX THIS FORM TO: Hand In Hand Hospice:**

**620-340-6178**

**Statement of Revocation or Transfer**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check the appropriate box:*

🞏 **Statement of Revocation**

I hereby revoke my election for **Medicare/Medicaid/Private Insurance** coverage of hospice care for the remainder of the current election period. I understand that:

* By revoking the hospice benefit, I am forfeiting the remainder of the days in that period.
* I can enroll in hospice any time in the future that I am determined to be eligible for hospice coverage.
* The Medicare/Medicaid/Private insurance benefits waived at the time of election will automatically resume on the effective date of this revocation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Effective date of Revocation***

**🞏 Transfer / Change of Designated Hospice Provider**

I hereby request to no longer receive hospice services from Hand In Hand Hospice, 1201 W. 12th Avenue, Emporia, KS 66801 and wish to transfer hospice services to:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Name of Agency***

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Address***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Phone Number of Agency*** ***Effective Date of Transfer***

*If I am a Medicare/Medicaid patient, I understand that changing to another Medicare/ Medicaid certified hospice program, one time in each period, does not result in loss of benefit days. I hereby authorize release of medical information to the above hospice provider*

**Patient or Authorized Representative Date**

**Relationship to Patient**

**Hand In Hand Representative Date**