Medicare Election Statement

Medicare Beneficiary's Name as on card | Medicare Number

I have read and received written and verbal explanations of the Medicare Hospice Benefit and hospice care as explained in consent for care.

I understand the following explanations of the Medicare Hospice Benefit:

1. Wellstar Community Hospice will receive payment for my care, relating to my terminal illness.
   a. I understand the purpose of hospice care and that the treatment is primarily palliative rather than curative.
   b. Medicare will continue to make payment to my independent attending physician for services if my physician is not a hospice employee not receiving payment from Wellstar Community Hospice.
   c. I waive my rights to Medicare benefits related to my terminal illness while enrolled on the Medicare Hospice Program.
   d. I am responsible for the cost for care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary team and documented on my plan of care.
2. I can change from one hospice to another, if I wish to do so. To change programs, I will confirm that I may be admitted to another hospice, and then I will inform Wellstar Community Hospice of my wishes so arrangements for transfer can be made. I will specify a date to discontinue care from Wellstar Community Hospice, the name of the hospice from which I wish to receive care, and the date care will start. In changing to another hospice program, I will not lose any benefit days. I may change hospices only once during each benefit period.
3. The Medicare Hospice Program consists of two 90-day periods, and unlimited 60-day periods if no revocations or discharges occur. I will use the benefit periods in the above order.
4. I may discontinue hospice care at any time by completing a revocation statement. If I revoke during a benefit period, I lose the remaining days in that benefit period. (example: If I revoke hospice care on the tenth day of the first 90-day benefit period, I give up the remaining 80 days of coverage). I may, however re-elect at any time when I am eligible.
5. I understand that if Wellstar Community Hospice has determined that Medicare will not pay for current Hospice services, I will receive a Notice of Medicare Provider Non-Coverage form no less than 14 days prior to discharge, per state regulations 290-9-43.14(4)(c)2, and federal regulations 418.26. I understand that I have the right to an immediate, independent medical review (appeal), while my services continue, regarding the decision to end Medicare coverage of hospice services. My request for an appeal should be made as soon as possible, but no later than noon of the day before the effective date the non-coverage indicated on the Notice received from Wellstar Community Hospice. The Quality Improvement Organization (QIO) for Georgia may be contacted at **(404) 982-0411**, or **www.gmcf.org**, TTY **1 (877) 486-2048**.
6. Name of attending physician designated by patient: _____

I elect the Medicare Hospice Benefit and acknowledge that the attending physician named-above is my choice.

Effective Date | Time

Beneficiary Signature

Or

Beneficiary's Representative Signature | Date | Time

Hospice Representative Signature | Date | Time