AVERY CARE HOSPICE, INC.

11030 Arrow Route, Ste 209, Rancho Cucamonga, CA 91730
Tel # 909-727-3200 Fax # 909-727-3082

MEDICARE HOSPICE BENEFIT REVOCATION

Patient Name:	MR #:	Date:	Time: ☐ AM ☐ PM

1. As a Medicare Hospice beneficiary, I wish to revoke the election of Medicare coverage of Hospice care for the remainder of benefit period #____________________.

2. I understand that I am forfeiting the right to ____days of Hospice coverage in the current benefit period. I can choose to re-elect the Medicare Hospice benefit at a later time without penalty.

The Benefit Periods are as follows:

☐ First Benefit Period……………………… 90 Days
☐ Second Benefit Period………………… 90 Days
☐ Third Benefit Period…………………… 90 Days
☐ Fourth Benefit Period…………………… 60 Days
☐ Ultimate Subsequent 60-day Benefit Period

3. I direct this revocation to be effective on ___/___/___. I understand that on this date the Medicare benefit, which I waived to receive Hospice Medicare coverage, will resume. The reason for revoking the benefit is____

____.

Signature of Patient or Legal Representative	*Date*

Relationship of Legal Representative to Patient	*Date*

Signature of Witness	*Date*

For Hospice reference only:

****** Hospice Revocation cannot be effective prior to the date this form is signed.***

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DISCHARGE INSTRUCTIONS

We at AVERY CARE HOSPICE, INC. are pleased to have provided service to you. The following discharge instructions were reviewed and discussed with you and your family/PCG during the final visit by the hospice staff in language YOU and PCG understand. You or your family are to:

- Make you scheduled appointment (s) with Dr. ________________ Tel# ________________
  Day __________________ Date _________________ Time ________________
  Be sure to keep your schedule appointment (s).

- Continue to take medications as prescribed by your physician. Refer to educational materials provided by the Pharmacist,

  Additional comments/instructions: ____
  ____

- Follow the diet as prescribed by your physician and instructed by the nurse.
  ____Regular diet no restrictions. ___You require the diet listed below:
  ___No added salt (NAS) ___No fat
  ___No sugar ___Special diet: _______
  ______Other: ____

- Follow through the community resources or organization to which you have been referred (describe) ____

- Other instructions (describe)____
  ____

  If you have questions concerning this instruction, please call your physician or **AVERY CARE HOSPICE, INC. at (909) 727-3200**. We hope that if you need home care in the future, you will contact us.

- Patient/ PCG/Family verbalized understanding of discharge instructions given.

RN Case Manager Name/ Signature: __________________________

Date: ________________

Patient/ PCG Signature: ____________________________________

Date: ________________ MR #: ____________________

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Notice of Medicare Non-Coverage

Patient name: ______________________________ **Patient number:** ______________

The Effective Date Coverage of Your Current Hospice Services Will End: ______________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current ____________________ (insert type) services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO). A BFCC-QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The BFCC-QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the BFCC-QIO generally will notify you of its decision by the effective date of this notice.
- Call your BFCC-QIO at: Livanta, 1- 866-815-5440, TTY: 1-866-868-2289, to appeal, or if you have questions.

See page 2 of this notice for more information.

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If You Miss the Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the BFCC-QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan Contact Information:

UPMC *for Life*
APPEALS & GRIEVANCES
PO BOX 2939
PITTSBURGH, PA 15230

CALL: 1-877-539-3080* **TTY/TDD:** 1-800-361-2629

*Our hours of operation change twice a year. You can call us **October 1 through February 14**, seven days a week from 8 a.m. to 8 p.m. From **February 15 through September 30**, you can call us Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

FAX: 1-412-454-7920

Additional Information (Optional):

Please sign below to indicate you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

______________________________ ______________________
Signature of Patient or Representative Date