ABBA HOSPICE, INC.

20955 Pathfinder Rd. Suite 332, Diamond Bar, CA 91765
Tel # 909-468-2033 Fax # 909-468-2018

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 ABBA 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 **ABBA HOSPICE, INC. at (909) 468-2033**. 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 #:** _____