Transfer/Change of Designated Hospice Provider

COLORADO
Palliative & Hospice Care

*Beneficiary Information**

Name:	Date of Birth:
Current Address:	Health Insurance Name and ID:
Contact Number:	Social Security #:
Guardian/Legal Representative Name:	Relationship:
Attending Physician:	Physician Phone #:

*** The above named Beneficiary requests that the designation of their current hospice provider be changed.**

Transferring From

Transferring Hospice Name:	Transferring Hospice Provider Phone #:

Transferring Hospice Provider Address:

Transferring To

Receiving Hospice Name:	Receiving Hospice Provider Phone#:

Receiving Hospice Provider Address:

Current Benefit Election Information

Current Benefit Election Period:	Current Certification Dates:

Current Hospice Diagnosis:

As a beneficiary of hospice services and by signing below, I understand that I am transferring to another Medicare certified hospice program and that I am able to transfer one time in each certification period without the loss of benefit days. I also understand that this request for change in hospice providers is not a revocation of the remainder of my current election period benefit. I hereby authorize the release of medical information to the above mentioned hospice provider.

Effective Date of Transfer:

Signature of Beneficiary or Legal Guardian/Representative	Date
Signature of Transferring Hospice	Date
Signature of Receiving Hospice	Date