FLORIDA MEDICAID HOSPICE CARE SERVICES
Revocation or Change Statement

Part I to be completed by the Hospice.

Date

Part I: **TO**: Department of Children and Families **FROM**:

Name of Hospice

Address

Address

RE:

Recipient's Name

Provider Number

Medicaid ID #

Patient Status

Attending Physician

Occurrence Date

Part II: ☐ I wish to change my designation of hospice from

TO

Name of Hospice

Name of Hospice

Address

Phone No.

Provider No.

Effective Date

☐ I wish to revoke my election of Medicaid services effective_________________________________.

Date

I understand that as long as I remain Medicaid eligible, with this revocation statement, my rights to coverage of all other Medicaid services will be resumed. If my Medicaid eligibility is dependent upon my election of and eligibility for hospice services, by revoking this election my entitlement to Medicaid is terminated.

Signature **Date**

In order to obtain information concerning your possible eligibility for other Medicaid assistance programs, please contact your social worker.

Distribution of Copies:
1. Coordinator
2. Physician
3. Hospice

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