MAP-376
(Rev. 12/11)

Change of Hospice Providers

I _______________________________ / ______________ wish to change the designation of
(Patient Name) (Member ID #)

the particular hospice from which I receive hospice care. I no longer wish to receive hospice service from _________________________________ / _________________ , but instead
(Provider Name) (Provider #)

wish to receive hospice care from _____________________________ / ________________
(Provider Name) (Provider #)

effective this __________________ day of ________________________ , 20 .

I understand that this change of hospice providers is not a revocation of the remainder of this election period.

_______________________________________ _______________________________________
Patient's Signature or Mark Witness' Signature

_______________________________________ _______________________________________
Date Date

Submit form to the local DCBS office.