MAP-375
(Rev. 12/11)

Revocation of Medicaid Hospice Benefits

I ________________________________ / ______________ , revoke the hospice benefit allowed
(Patient Name) (Member ID #)

to me by Medicaid and rendered by ____
(Hospice Agency)

____________________ this ________ day of ____________________________ , 20 ____.
(Provider #)

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later date.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

I understand, however, that based on this revocation, I may become ineligible for Medicaid benefits.

____ ____
Patient's Signature or Mark Witness' Signature

____ ____
Date Date

FOR OFFICE USE ONLY

Reason of Revocation:

Submit form to the local DCBS office.