Patient Name & HPC #: ___________________________
(place sticker here)

HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY
PERDIEM INSURANCE BENEFIT

I, ________________________________, choose to receive hospice care from Hospice & Palliative Care of Greater Wayne County. I acknowledge the following:

1. Hospice care is not curative. Supportive, palliative care is provided by the hospice. The program's goal is not to cure my terminal illness, but to reduce symptoms such as pain or nausea and to provide emotional and spiritual support.

2. I choose hospice care and elect my hospice insurance benefit as the payment source for all services and treatment related to my terminal diagnosis of:

   ____

   I understand that my insurance company has agreed to reimburse Hospice & Palliative Care of Greater Wayne County on the following basis:

   - □ Per Diem for the following levels of care (□ routine home care, □ respite, □ continuous, and □ inpatient symptom management)
   - □ Other ____

   I understand that I have been given information on the limits of my insurance hospice benefit and my financial responsibilities as follows:

   Primary Insurance ___________________________ ***Effective Date*** ___/____/___

   Coverage at ____

   Deductible ___________***.00 to*** ________***% Out-of Pocket*** _______***.00 to*** ________***%***

   Deductible satisfied? Yes/No ***Out-of Pocket Satisfied? Yes/No***

   Yearly Maximum ______________***: Lifetime Maximum*** _______________________

   Case Management? Yes/No

   Secondary Insurance ____

   Comments ____

   ____

   I understand that insurance verification does not guarantee payment

   I understand that I remain responsible for all co-payment and/or deductibles for covered services as outlined in my insurance benefit and that I must complete a financial form to determine the portion that I am able to pay.

I understand that I must have prior approval from hospice before ordering or receiving treatment, supplies, equipment, or any other services related to the diagnosis listed above.

I understand that if I fail to get preauthorization from hospice for any treatments, services, equipment, supplies, etc. related to this diagnosis I will be financially responsible for any charges incurred.

I understand that my doctor will bill my primary insurance directly as is currently being done.

3. My insurance will continue to be billed for care not related to the diagnosis listed above.

4. I understand I may revoke this agreement at any time by signing a statement to that effect. If I choose to revoke this agreement, HPC will no longer be responsible for any charges incurred.

ACKNOWLEDGING THE ABOVE, I AUTHORIZE HOSPICE INSURANCE COVERAGE FOR HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY TO BEGIN ON: ________________________.

(I UNDERSTAND THAT ELECTION BEGINS AS OF THIS DATE AND CANNOT PRECEDE THE DATE OF MY SIGNATURE BELOW).

______________________	______________________________________
Date of Signature	Signature of Patient or Legal Representative
______________________	______________________________________
Date of Signature	Witness Signature
______________________	______________________________________
Date of Signature	Signature of Hospice Representative/ Title

For Office Use Only: **Insurance #**____

Attending Physician ____