HOSPICE ELECTION COMMUNICATIONS FORM

Fax To: UCare Medicare Enrollment at 612-884-2088

Name _____ ☐ Male ☐ Female Date of Birth _____

UCare ID # _____ SS # _____ PCC _____

Completed By: _____ Date: _____

HOSPICE ADMISSION

Hospice Provider: _____

Admission Date: _____

ICD-10 Code: _____

Diagnosis: _____

HOSPICE CHANGE IN ELECTION

Revocation Date: _____
(The member has elected to revoke their Hospice care)

Term Date: _____
(The Hospice has terminated the member's care)

*Please fax this form to UCare within 48 hours when a UCare Medicare, UCare Medicare with M Health Fairview & North Memorial, EssentiaCare, MSC+, MSHO, UCare Connect or UCare Connect + Medicare member elects, terms or revokes Hospice services.

Revised 1/13/2020