Wyoming Department of Health

Hospice Benefit Revocation Form

Hospice Provider: _____

Hospice NPI: _____

Client Name: _____

Client Medicaid Number: _____

Physician Name: _____

Physician NPI: _____

Date of Hospice Election: _____

Date of Revocation: _____

Number of Days Remaining: _____

I,_____ hereby revoke my election to Hospice Care for the remainder of the current election period.

I understand that I am no longer covered under the Hospice benefit plan for hospice services. If covered by Medicare/Medicaid/Champus, I may resume regular benefits previously waived.

I understand that I may again elect to receive hospice benefits for any additional hospice election periods for which I am eligible.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Mail to: Wyoming
Medicaid Attn: Provider
Relations PO Box 667
Cheyenne, WY 82003-0667

Submit a copy of this form to the Long Term Care Unit via fax at (307)777-8399 or email to ltcunit@wyo.gov.