MAP-375
(Rev.
10/21)

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:

Clear Form