SKIRBALL HOSPICE
A program of the
Los Angeles Jewish Home

6345 Balboa Blvd., Suite 315
Encino, CA 91316
24 hour phone: 818.774.3040 • Fax: 818.774.3089
www.skirballhospice.org

Election of Hospice Benefit:

Financial Arrangements: Medicare / Medi-Cal / Commerical Insurance

As a Medicare Part A, Medi-Cal or Commercial Insurance beneficiary, I hereby elect SKIRBALL HOSPICE as my sole provider of hospice care effective (date) _____. If I am a Medicare or Medi-Cal Beneficiary, I understand that when I elect the hospice benefit I thereby waive General Medicare coverage related to my hospice diagnosis and accept hospice care for my hospice diagnosis.

I understand that while this election is in force, my insurance carrier will make payments for care related to this diagnosis. Services related to this Hospice diagnosis provided by hospitals, home health agencies, nursing homes and any other company or agency will not be reimbursed by my insurance carrier unless specifically ordered and authorized by SKIRBALL HOSPICE. I understand the services not related to this diagnosis will continue to be covered by my insurance carrier along with hospice benefits. I understand that should my health care coverage fail to reimburse for services, supplies, medical equipment and/or medications rendered, that I acknowledge financial responsibility for payment/coinsurance/deductible amounts in accordance with my coverage. I understand the explanations given to me regarding my financial obligation(s) and the cost of services if my health care insurance does not pay for services provided. I will be made aware of such non covered services prior to receiving them. I understand that if I require hospitalization or special services not related to my hospice diagnosis, my representative or I must make the arrangement for those services and that I am financially responsible for those services.

Acknowledgement

I acknowledge and agree to the terms and conditions described herein:

_____ _____
Signature of Patient Date

If patient unable to sign, state reason: _____

_____ _____
Signature of Legally Authorized Representative (If Applicable) Date

_____
Name of Legal Representative (Print) (If Applicable)

_____
Address of Legal Representative (Print) (If Applicable)

_____
Hospice Representative

_____ _____
Patient MR #