## Addendum to the Election Statement/ Consent for Hospice Care Medicare & Medicaid



wish to change th	he attending physician for(beneficiary)	(beneficiary name)	
the following	as o		
	(physician or nurse practitioner name)	(date)	
acknowledge tha	t this change in the medical provider is my choice.		
delalowiedge tild	t this change in the incurcui provider to my choice.		
Date	Client/POA/Representative Signature		
2 4.00	622621, 2 612, 116P1 66 62111111 6 628111111 6		
Б.,			
Date	Tabitha Hospice Witness Signature		