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

TABITHA

I wish to change the attending physician for ______________________________
(beneficiary name)

to the following ______________________________ as of ______________.
(physician or nurse practitioner name) *(date)*

I acknowledge that this change in the medical provider is my choice.

______________ ______________________________
Date Client/POA/Representative Signature

______________ ______________________________
Date Tabitha Hospice Witness Signature