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

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 medical provider is my choice.

_____ _____
Date Client/POA/Representative Signature

_____ _____
Date Eventide Hospice Witness Signature