

**GILCHRIST HOSPICE CARE**  
**555 W. Towsontown Blvd.**  
**Baltimore, MD 21204**  
**(443) 849-8200**

**CHANGE OF HOSPICE**

I, \_\_\_\_\_ wish to discontinue Hospice care from  
\_\_\_\_\_ on \_\_\_\_\_

As of \_\_\_\_\_, I wish to receive Medicare Hospice care from  
\_\_\_\_\_.

Date of original Medicare Hospice Benefit Election Period \_\_\_\_\_.

I understand that no benefit days will be lost by changing to another hospice program. I may change hospices only once in each benefit period.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

White-Medical Records    Yellow-Accounting    Pink-Patient