Wyoming Department of Health

Hospice Benefit Revocation Form

Hospice Provider Name	____________________	**Hospice Provider NPI/Provider Number**	____________
Member Name	____________________	**Member ID**	____________
Physician Name	____________________	**Physician NPI**	____________
Date of Hospice Election	____________	**Number of Days Remaining**	____________
Date of Revocation	____________		

I, ____, hereby revoke my election in Hospice Care for the remainder of the current election period.

I understand that I am no longer covered under the Hospice benefit plan for hospice services. If covered by Medicare/Medicaid/Champus, I may resume regular benefits previously waived.

I understand that I may again elect to receive Hospice benefits for any additional hospice election periods for which I am eligible.

Member Signature ________________________________ **Date** ____________
mm/dd/yyyy

Witness Signature ________________________________ **Date** ____________
mm/dd/yyyy

Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Provider Services
P.O. Box 1248
Cheyenne, WY 82003-1248

Submit a copy of this form to the Long Term Care Unit via fax at (309)777-8399 or email to ltcunit@wyo.gov.

WYBMS-Hospice Benefit Revocation form