

HOSPICE INFORMATION for MEDICARE PART D PLANS

SECTION II – PLAN OF CARE (Optional)

Hospice Name _____ **Hospice NPI** _____

Patient Name _____ **Patient ID# (HICN)** _____ **Patient DOB** ____/____/____

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
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Signature of Hospice Representative

Representative _____ Date ____/____/____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative _____ Date ____/____/____