ALLEVIATE HOSPICE CARE INC.
13098 Borden Ave Sylmar, CA 91342
Phone: (818) 433-4558 * Fax: (818) 452-3833
E mail: alleviatehospicecareinc@gmail.com

TRANSFER OF MEDICARE/MEDICAL HOSPICE BENEFIT

_____ wish to transfer the election of my

Medicare/Medical Hospice from _____

To **ALLEVIATE HOSPICE CARE INC.**

I understand that in transferring from one agency to another I lose non of my benefits, nor do I forfeit any days in the current or subsequent certification period(s). This transfer is effective immediately, as of the date of signature below.

I make this decision after careful consideration and of my own free will.

(Return to Office)

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____

HOSPICE REPRESENTATIVE: _____