HOSPICE ELECTION COMMUNICATIONS FORM

Fax To: Aspirus Health Plans Enrollment at 715-787-7305

Name _____ ☐ Male ☐ Female Date of Birth _____

Aspirus Health Plan ID #_____ SS # _____

PCC _____

Completed By:_____ Date: _____

HOSPICE ADMISSION

Hospice Provider: _____

Admission Date: _____

ICD-10 Code: _____

Diagnosis: _____

HOSPICE CHANGE IN ELECTION

Revocation Date: _____
(The member has elected to revoke their Hospice care)

Term Date: _____
(The Hospice has terminated the member's care)

*Please fax this form to Aspirus Health Plans within 48 hours when a member elects, terms or revokes Hospice services.

Revised 1/27/2022