CHANGE OF ATTENDING PHYSICIAN

❍ I ❍ my designated representative for, _____
NAME–First, MI, Last

(Social Security #_____), choose to change my currently designated attending physician from:

_____ (_____)
Full Name - First, MI, Last NPI #

located at (office address):

To the following physician:

_____ (_____)
Full Name - First, MI, Last NPI #

located at (office address):

Effective Date of Change: _____
Month/Day/Year

(Date change can be no earlier than the date the statement is signed.)

I understand that by choosing to change my current attending physician it will not affect the conditions of my current benefit period.

By signing below, I acknowledge that this change in the attending physician is:

❍ my choice

❍ my designated representative's choice

Date: _____ _____
Month/Day/Year Signature of Patient or Designated Representative (if Patient Is Unable to Sign)

Date: _____ _____
Month/Day/Year Signature of Hospice Representative