TRI CITY HOSPICE INC.
13096 Borden Ave Sylmar, CA 91342
Phone: (818) 433-4524 * Fax: (818) 452-5011
E-mail: tricityhospiceinc@gmail.com

TRANSFER OF MEDICARE/MEDICAL HOSPICE BENEFIT

_____ wish to transfer the election of my

Medicare/Medical Hospice from _____

To **TRI CITY HOSPICE 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: _____