



**UCARE FOR SENIORS/MSHO/UCare Connect  
HOSPICE ELECTION COMMUNICATION  
FORM**

**Fax To: UCare Medicare Enrollment at 612-884-2088**

Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_

UCare ID # \_\_\_\_\_ SS # \_\_\_\_\_ PCC \_\_\_\_\_

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

**HOSPICE ADMISSION**

Hospice Provider: \_\_\_\_\_  
Admission Date: \_\_\_\_\_  
ICD-9 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 UCare within 48 hours when a UCare for Seniors, MSHO or UCare Connect member elects, terms or revokes Hospice services.\***