MAP-379
(Rev. 12/11)

Representative Statement
For Election of Hospice Benefits

Representative Statement for Election of Hospice Benefits

I, _____ , due to the physical/mental
(Legal Representative)
incapacity of _____ am authorized
(Patient Name/Member #)
in accordance with state laws to execute, change or revoke the election of Medicaid Hospice on behalf of _____ who has been certified as terminally ill.

As the representative for _____ , I will sign all necessary forms.

_____ _____
Signature, Legal Representative Date

_____ _____
Witness Date

CLEAR FORM