Beneficiary Elected Transfer / Right of Choice Statement

Patient name: _____ Date: _____

Discovery efforts:

☐ HIQH Query /Customer Service indicates Patient under an established home health plan of care

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I, _____, choose to transfer to

Community Care Health Agency, Inc.

From:

_____

(Initial home health agency).

Effective transfer date _____.

I understand the initial home health agency will no longer receive Medicare Payment on my behalf and will no longer provide Medicare covered services to me after the effective date of transfer.

I request that my records be released to the receiving agency to ensure continuity of care.

_____

Patient/Beneficiary Signature Date

For Agency Use Only

Coordination of Transfer:

☐ Phone call to _____ (initial home health agency) for coordination of transfer on _____

Contact person: _____

☐ Beneficiary Elected Transfer/Right of Choice form sent /faxed to Initial agency on _____

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