Iowa Department of Human Services

REVOCATION OF MEDICAID HOSPICE BENEFIT

I, _____ (Recipient's name), _____ (Medicaid number),

choose to revoke the hospice benefit allowed to me by Medicaid and rendered by

_____ (Agency name), _____ (Agency provider number), as of

_____, 20 _____.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

Recipient's signature	Witness' signature
Date	Date

470-2619 (7/05)