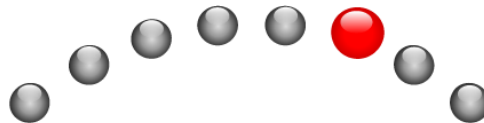


Election Statement (EOB) Form Audit Tool

Date: _____

Requirement	Results	Comments
Place for effective date of election	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Identification of the particular hospice that will provide care to the patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Identification of the attending physician that will provide care to the patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acknowledgement that attending physician was his/her choice.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Place for signature of patient or representative	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Place for explanation why patient cannot sign	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acknowledgement of patient's or representatives full understanding of hospice care (palliative versus curative), services offered and any limitations to services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
The patient's or representative's acknowledgement that the patient understands that certain Medicare services are waived by the election	<input type="checkbox"/> Yes <input type="checkbox"/> No	



HOSPICE FUNDAMENTALS

KNOWLEDGE • EXPERTISE • COMMON SENSE