Pacific Home Health Care
4136 N. Kedzie Ave., Chicago, IL 60618-2440
Phone: 773 463.1047 Fax: 773 463.1485
www.PacificHHC.com

BENEFICIARY ELECTED TRANSFER

Name of Patient: ____

Complete Address: ____

I ____ fully understand that I am now electing Pacific Home
(Name of patient)
Health Care, Inc. to provide me with home health services effective today.

I also understand that my previous home health agency ____
(Name of Home Health Agency)
will no longer provide home health services and receive any payment from my health insurance on my behalf.

I am aware that I am responsible in contacting ____ to inform
(Name of Home Health Agency)
them of my intent. In addition, I authorized Pacific Home Health Care, Inc. to contact ____________________________________ to ensure continuity of service.
(Name of Home Health Agency)

____
Patient Name (Print)

______________________________________ ____________________
Signature of Patient/Responsible party (Relationship) *Date*

______________________________________ ____________________
Pacific Home Health Care, Inc. (Representative) *Date*