Hospice Care Eligibility Confirmation

Date: [Insert Date]

[Recipient's Name]

[Recipient's Address]

[City, State, ZIP Code]

Dear [Recipient's Name],

This letter is to confirm the eligibility of [Patient's Full Name] for hospice care services provided by [Hospice Service Provider's Name]. After a comprehensive evaluation, it has been determined that the patient meets the criteria for hospice care as outlined in the Medicare and insurance guidelines.

The patient has a prognosis of [insert prognosis, e.g., six months or less to live], and the focus of care will be on comfort and quality of life rather than curative treatment. This decision has been made in consultation with the patient's healthcare team and family members.

For insurance verification purposes, please find the necessary details below:

- Patient's Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Insurance Provider: [Insurance Provider's Name]
- Policy Number: [Policy Number]

If you have any questions or require further information, please do not hesitate to contact our office at [Hospice Service Provider's Phone Number] or [Hospice Service Provider's Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Hospice Service Provider's Name]

[Hospice Service Provider's Address]

[City, State, ZIP Code]

[Phone Number]

[Email Address]