Opt-Out Affidavit

Provider Name _____
(First) (Middle) (Last) (Cred)
Provider Address _____
(Street) (City) (ST) (Zip)
Social Security Number: _____ Date of Birth: _____ Specialty _____

Medicare PTAN(s)_____ NPI Number _____

Telephone (___)_____ License Number _____

Contact Name:_____ Phone #: _____ Fax #_____

Contact Email _____

• Except for emergency or urgent care services (as specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §3044.8 for services that, but for their provision under a private contract, would have been Medicare-covered services. **The opt out period is 2 years and the contractor will notify me of the effective date of this opt out period.**

• I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual.

• During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.

• I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

• I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.

• I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the 2 year opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

• I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit. My affidavit should be submitted to the contractor within 30 days of the end of the quarter.

• I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of Chapter 15 Section 40 of the Medicare Benefit Policy Manual apply if I furnish such services.

• I have identified myself sufficiently so that the contractor can ensure that no payment is made to me during the 2 year opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN and NPI, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to be assigned a PTAN.

• I will file this affidavit with all contractors who have jurisdiction over claims that I would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

_____ _____
Provider Signature Date

NOTE: please submit a private contract with your affadavit. When submitting this contract to Medicare Part B, only the provider's signature is needed.

Private Contract

• I _____ (provider's name), have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act.

• I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by _____.

• I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what _____ may charge for items or services furnished.

• I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask _____ to submit a claim to Medicare.

• I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by _____ that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

• I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

• The expected or known effective date and expected or known expiration date of the opt-out period is _____ (effective date) and _____ (expiration date).

• I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

• I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

• I _____ (provider's name) will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

• I _____ (provider's name) will supply CMS with a copy of this contract upon request.

• I _____ (provider's name) understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____	_____
(Provider's Signature)	(Date)
_____	_____
(Patient's Signature)	(Date)
_____	_____
(Patient's Legal Representative Signature)	(Date)
_____	_____
(Witness)	(Date)