national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Medicare Opt-Out Affidavit

I, _____, being duly sworn, depose and say:

(*Enter Physician/Nonphysician Practitioner Name*)

1. Opt-out is for a period of two years. At the end of the two-year period, my opt-out status will automatically renew. If I wish to cancel the automatic extension, I understand that I must notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.
2. Except for emergency or urgent care services (as specified in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) *Medicare Benefit Policy Manual,* Publication 100-02, Chapter 15, §40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
3. 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 §40.28.
4. 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 Advantage.
5. 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.
6. 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.
7. 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 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.
8. I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
9. 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 §40.28 apply if I furnish such services.
10. I have identified myself sufficiently so that the carrier can ensure that no payment is made to me during the opt-out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.

11. I will file this affidavit with all MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two-year opt-out period will begin the date the affidavit meeting the requirements of *42 Code of Federal Regulations*, §405.420 is signed, provided the affidavit is filed within ten days after the physician/practitioner signs the latter's first private contract with a Medicare beneficiary.

Please refer to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §40.9, for additional Medicare regulations that apply to entering into private contracts.

Only eligible provider types may opt out of Medicare and enter into private contracting. Once an eligible provider is opted out, his/her opt out status will remain active and auto-renew every two years from the effective date of the opt-out period. In order to terminate an opt out status, the provider must notify the appropriate contractor in writing of his/her intent and/or complete an CMS-855 application to gain Medicare billing privileges within the time frame outlined in the CMS IOM prior to the auto renewal period. Additionally, if a provider wishes to terminate after initially opting out, it must be done within 90 days from the opt out effective date.

Please note that an opt-out status in Medicare does not allow a provider to continue participating in any Medicare Advantage Programs.

All items below represent the minimum information required to opt out, please ensure all items have been completed:

Provider Information

Full Legal Name

First: _____

Middle:_____ *(please write N/A if not applicable)*

Last: _____

Date of Birth (DOB): _____

Social Security Number (SSN): _____

National Provider Identifier (NPI) _____

Do you wish to order/certify:

☐ Yes

☐ No

***This allows certain eligible specialties to order and refer (O&R) services or prescribe Part D drugs for Medicare beneficiaries while opted out. In order to O&R, your SSN, DOB and NPI are required to be reported on the affidavit.*

License Information

Number: _____

State Issued:_____

Effective Date: _____

Specialty

☐ Doctor of Medicine (MD): Primary/Secondary Specialty:_____

☐ Doctor of Osteopathy (DO): Primary/Secondary Specialty:_____

☐ Doctor of Dental Surgery (DDS): Primary/Secondary: _____

☐ Podiatrist ☐ Optometrist ☐ Physician Assistant

☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Certified Registered Nurse Anesthetist

☐ Certified Nurse Midwife ☐ Clinical Psychologist ☐ Clinical Social Worker

☐ Registered Dietitian or Nutrition Professional

☐ Marriage & Family Therapist

☐ Mental Health Counselor

Principal Office Information (*cannot be a PO Box*):

Address Line 1: _____

Address Line 2: _____

City: _____ State:_____ZIP + 4:_____

Email: _____

Telephone:_____ Fax: _____

Contact Person *(if different than provider)*

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____State:_____ZIP + 4:_____

Email: _____

Telephone:_____ Fax: _____

Signature of provider _____ Date: _____

Please mail the completed Opt Out affidavit forms to the following address as appropriate:

Jurisdiction 6 (IL, MN, WI)	Jurisdiction K (CT, MA, ME, NH, NY, RI, VT)
National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178