Medicare Opt Out Affidavit

I, ____, being duly sworn,
(*Full name of physician*)

depose and say on this date _______________________:

1. I promise that, except for emergency or urgent care services (as specified in Centers for Medicare & Medicaid Services [CMS] Internet-Only Manual [IOM] Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
2. I promise that I will not submit any claim to Medicare for any item or service provided to any 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 the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 40.28.
3. I understand that, during the opt-out period, I may receive no direct or indirect Medicare payment for services which 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 plan.
4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
5. I promise that, during the opt-out period, I will be bound by the terms of both this affidavit and the private contracts that I enter into with Medicare beneficiaries.
6. I acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me 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.
7. I 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 the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Section 40.28 apply if I furnish such services.
8. [*Applies to physicians who have signed a Part B participation agreement.*] I acknowledge that my Part B participation agreement terminates on the effective date of this affidavit.

Please refer to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 40, for additional Medicare regulations that apply to entering into private contracts.

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

Provider's Legal Name: ____

Principal Office Address (cannot be P.O. box): ____________________________________

Telephone Number: ________________________ Fax Number: ___________________________

Provider's E-mail Address:____

Medicare Provider Transaction Access Number (PTAN) (if one has been assigned): ______________

Provider's Social Security Number (SSN): ______________________________________

Specialty (i.e., Internal Medicine, etc.): ______________________________________

Date of Birth: ____

NPI: ____

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 7149 Indianapolis, IN 46207-7149