Opt-Out Affidavit

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

Medical School: _____ Year Graduated: _____

Medicare PTAN(s): _____ NPI Number: _____

Telephone: (____) _____ Tax ID: _____ 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 will automatically renew. To cancel, a written request must be submitted to the contractor 30 days prior to the end of the 2 year 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

Please submit your affidavit to:
Novitas Solutions
Provider Enrollment Services
PO Box 3157
Mechanicsburg, PA 17055
or you may fax to (717) 728-8759