

(2) MEDICARE OPT-OUT AFFIDAVIT

TWO COPIES OF THIS AFFIDAVIT SHOULD BE COMPLETED—ONE MUST BE FILED WITH YOUR MEDICARE CARRIER (SENT BY REGISTERED MAIL, RETURN RECEIPT REQUESTED) AND THE OTHER SHOULD BE KEPT ON FILE IN YOUR OFFICE.

I, _____, being duly sworn,

Full Name of Physician

depose and say:

1. I promise that, except for emergency or urgent care services (as specified in 42 C.F.R. §405.440), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 42 C.F.R. §405.415 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 2-year period beginning on the following effective date: _____; 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 42 C.F.R. §405.440.
3. I understand that, during the opt-out period, 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.
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 42 C.F.R. §405.440 apply if I furnish such services.
8. *[Section 8 should be used only for those physicians who have signed a Part B participation agreement.]* I acknowledge that my Part B participation agreement terminates on the effective date of the affidavit.

Signature of Physician

Principal Office Address

Telephone Number

National Provider Identifier (NPI)

Uniform Provider Identification Number (UPIN), if one has been assigned

Sworn to and subscribed before me

this _____ day of _____

Notary Public