OPT-OUT AFFIDAVIT

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When a physician/practitioner opts-out of Medicare, no Medicare payment can be made to that physician or practitioner. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician or practitioner who has opted out of the program. * indicates required fields.

Eligible Practitioner Information			
Eligible practitioners should include the following information (to complete an affidavit record in PECOS)			
Eligible Practitioner's First, Middle and Last Name*			Credentials
Physical Location/Address*			
City*	State*		Zip*
Telephone Number*	Social Security Number		Date of Birth*
Specialty			NPI Number
License Number*	Email		Medicare Identification Number
Eligible Practitioner's Wishes to Order & Refer	☐ Yes	☐ No	

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

- 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.

- Except for emergency or urgent care services (as specified in the 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.

- 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.

- 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 Medicare Advantage.

- 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 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.

- 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.

- I have identified myself sufficiently so that the MAC 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.

- 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 C.F.R. §405.420 is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Signature	
Provider Signature*	Date*

Note: This form must be printed and mailed with an original signature from the provider. A signature from the contact on the application will not be accepted. Please mail request to your Medicare Administrative Contractor (MAC). Your MAC will have the proper mailing address on its website. To locate your MAC, go to www.cms.gov/MedicareProviderSupEnroll. Providers who render services in multiple states, must have affidavits filed with all MACs who have jurisdiction over claims the physician/practitioner would otherwise file with Medicare.