## MEDICARE OPT-OUT NOTICE

Medicare contractor address:

_____

_____

_____

Attn: Provider Enrollment

I, _____ , declare under penalty of perjury that the following is true and correct to the best of my knowledge, information and belief:

1. I am a physician licensed to practice medicine in the state of_____. My address is _____

_____ , my telephone number is_____,

my national provider identifier or uniform provider identification number is _____. I promise that, for a period of two years beginning on the date that this affidavit is signed (the "Opt-Out Period"), I will be bound by the terms of both this affidavit and the private contracts that I enter into pursuant to this affidavit. I acknowledge that any Part B participation agreement that I have signed terminates on the effective date of this affidavit.

2. I have entered or intend to enter into a private contract with a patient who is a beneficiary of Medicare ("Medicare Beneficiary") pursuant to Section 4507 of the Balanced Budget Act of 1997 for the provision of medical services covered by Medicare Part B. Regardless of any payment arrangements I may make, this affidavit applies to all Medicare-covered items and services that I furnish to Medicare Beneficiaries during the Opt-Out Period, except for emergency or urgent care services furnished to Beneficiaries with whom I had not previously privately contracted. I will not ask a Medicare Beneficiary who has not entered into a private contract and who requires emergency or urgent care services to enter into a private contract with respect to receiving such services, and I will comply with 42 C.F.R. § 405.440 for such services.

3. I hereby confirm that I will not submit, nor permit any entity acting on my behalf to submit, a claim to Medicare for any Medicare Part B item or service provided to any Medicare Beneficiary during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation for which I am required to submit a claim under Medicare on behalf of a Medicare Beneficiary, and I will provide Medicare-covered services to Medicare Beneficiaries only through private contracts that satisfy 42 C.F.R. § 405.415 for such services.

4. I hereby confirm that I will not receive any direct or indirect Medicare payment for Medicare Part B items or services that I furnish to Medicare Beneficiaries with whom I have privately contracted, whether as an individual, as an employee of an organization, as 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, during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation. I acknowledge that, during the Opt-Out Period, my services are not covered under Medicare Part B and that no Medicare Part B payment may be made to any entity for my services, directly or on a capitated basis, except for items or services provided in an emergency or urgent care situation.

5. A copy of this affidavit is being filed with _____ , the designated agent of the Secretary of the Department of Health and Human Services, no later than 10 days after the first contract to which this affidavit applies is entered into.

Executed on _____[date] by _____[Physician name]

_____[Physician signature]

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