Medicare Opt-Out Affidavit

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

(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, if I wish to remain opt-out, I will complete a new affidavit that is submitted to the carrier, as well as issuing new contracts with my patients.
- 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 a 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 carrier 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 carriers 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.

_____ Date _____

Physician Signature

The following information is necessary to complete your Opt-Out request, please provide all applicable information.

Physician Address: Address _____ Telephone Number _____

City _____ State _____ Zip Code _____ Specialty _____

NPI _____ PTAN (if applicable) _____

Social Security Number _____ Date of Birth _____

School Information _____ Year of Graduation _____

Tax ID (if applicable) _____ Also, please provide a copy of applicable licensure.

Mail form to: J1 MAC - Palmetto GBA
P.O. Box 1508
Augusta, GA 30903-1508

Overnight: J1 MAC - Palmetto GBA
Attn: Provider Enrollment
2743 Perimeter Parkway
Bldg 200 - 2nd Floor
August, GA 30909

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