National Government Services
A CMS Medicare Administrative Contractor

MEDICARE

Medicare Opt-Out Affidavit

I, ____, being duly sworn, depose and say:
(*Enter Physician/Nonphysician Practitioner Name*)

1. Opt out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew every two years. If I wish to cancel the automatic extension, I will notify my Medicare Administrative Contractor (MAC) in writing at least 30 days prior to the start of the next two-year opt-out period.
2. Except for emergency or urgent care services (as specified in the Centers for Medicare & Medicaid Services [CMS] Internet-Only Manual [IOM] Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 40.28), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of Section 40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
3. 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 Section 40.28.
4. 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.
5. 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.
6. 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.
7. 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.
8. I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
9. 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 Section 40.28 apply if I furnish such services.
10. 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.

11. 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 Code of Federal Regulations*, Section 405.420 is signed, provided the affidavit is filed within ten days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

Please refer to the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 40, for additional Medicare regulations that apply to entering into private contracts.

Only eligible provider types may opt out of Medicare and enter into private contracting. Once an eligible provider is opted out, his/her opt out status will remain active and auto-renew every two years from the effective date of the opt-out period. In order to terminate an opt out status, the provider must notify the appropriate contractor in writing of his/her intent and/or complete an CMS-855 application to gain Medicare billing privileges within the time frame outlined in the CMS IOM prior to the auto renewal period. Additionally, if a provider wishes to terminate after initially opting out, it must be done within 90 days of receipt of an opt-out approval letter.

Please note that an opt-out status in Medicare does not allow a provider to continue participating in any Medicare Advantage Programs.

All items below represent the minimum information required to opt out, please ensure all items have been completed:

Provider's Legal Name: ______________________________

Principal Office Address 1 (cannot be P.O. box): ______________________________

Office Address 2 (suite, room, etc.):______________________________

City: ____________ State: ____________ZIP + 4: ____________

Telephone Number: ____________ Fax Number: ____________

Provider's E-mail Address: ______________________________

Medicare Provider Transaction Access Number (PTAN) (if one has been assigned): ____________

Provider's Social Security Number (SSN): ______________________________

Date of Birth:____________ NPI:____________

License Number ____________ License State of Issuance ____________

License Effective Date ____________

Do you wish to order/refer?____________

Specialty

☐ Doctor of Medicine (MD): Primary/Secondary Specialty:______________________________

☐ Doctor of Osteopathy (DO): Primary/Secondary Specialty:______________________________

☐ Podiatrist ☐ Optometrist ☐ Physician Assistant

☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Certified Registered Nurse Anesthetist

☐ Certified Nurse Midwife ☐ Clinical Psychologist ☐ Clinical Social Worker

☐ Registered Dietitian or Nutrition Professional

Contact Person: Name ____

Phone Number: ________________________ Email:________________________________

Address 1: ____

Address 2 (suite, room, etc.):____________________________________

City: ______________________ State: _____________________ZIP + 4: __________________

Signature of provider ____________________________________ Date:___________________

Please mail the completed Opt Out affidavit forms to the following address as appropriate:

Jurisdiction 6 (IL, MN, WI)	**Jurisdiction K (CT, MA, ME, NH, NY, RI, VT)**
National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475	National Government Services, Inc. P.O. Box 7149 Indianapolis, IN 46207-7149