

Sample Medicare Opt Out Affidavit

For purposes of opting out of the Medicare program in order to privately contract with Medicare beneficiaries to provide Medicare covered services and items, I hereby state and affirm as follows:

1. My full name is:

My address is:

My telephone number is:

My Medicare Specialty is:

My National Provider Identifier (NPI) or billing number (if assigned) is:

If an NPI has not been assigned, my tax identification number (TIN) is:

If I was previously enrolled in Medicare and was assigned a Medicare Billing ID/Provider Transaction Number (PTAN), my PTAN is:

2. Except for emergency care or urgent care services for patients with whom I have not privately contracted, during the opt-out period, I shall provide services to Medicare beneficiaries only through private contracts for services that, but for the private contract, would have been Medicare covered services.

3. Except for emergency or urgent care services for a patient with whom I have not privately contracted, I shall not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor shall I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary.

4. I understand that during the opt-out period, I may not receive any 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 services to a Medicare beneficiary under a Medicare Advantage plan.

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 that during the opt-out period, I agree to be bound by the terms of both this affidavit and the private contracts into which I have entered.

7. I acknowledge that I recognize that the terms of the 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 beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

8. If I have signed a Medicare Part B participation agreement, I acknowledge that such agreement terminates on the effective date of this affidavit.9. I acknowledge that I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care may not be asked to enter into a private contract with respect to receiving such services and that the rules set forth in 42 CFR 405.440 apply if I provide such services.

I declare under penalty of perjury that the foregoing is true and correct.*

Signature: _____

Name (print): _____

Date: _____

* If signed outside the United States, the following declaration should be used instead:

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

This Affidavit is for filing with all carriers who have jurisdiction over claims Dentist would otherwise file with Medicare, within 10 days after the first Private Contract to which the Affidavit applies is entered into.

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