Medicare Opt Out Affidavit

This form should ONLY be completed and mailed to WPS Government Health Administrators if you are Opting Out in J5 (Iowa, Kansas, Missouri, Nebraska) or J8 (Indiana and Michigan).

Eligible Practitioner's Full Name:

Practice Address (Street, City, State, ZIP)

Email Address:

Telephone Number:

National Provider Identifier:

Date of Birth:

Social Security Number:

License Number:

State of Licensure:

Specialty:

Medicare Identification Number(s) (PTANs) (if issued):

Do you wish to order and refer? Yes ◯ No ◯

I, _____, being duly sworn, depose and say:
(Practitioner's Name)

- 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 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.

- 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.

- 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 section 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 CFR section 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: _____ Date signed: _____

Please mail this completed form to:

Regular Mail	**Overnight Delivery Address**
WPS Government Health Administrators Medicare Provider Enrollment PO Box 8248 Madison, WI 53708-8248	WPS Government Health Administrators Medicare Provider Enrollment 1717 W. Broadway Madison, WI 53713-1834

Note: This affidavit form was prepared by Wisconsin Physicians Service, Medicare Part B, based on the provisions of the Code of Federal Regulations 42 CFR 405.400ff. and implementing directives in the CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 40.9 and IOM Publication 100-08, Program Integrity Manual, Chapter 10, Section 10.6.12.