NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission

CMS-8550 Enrollment & Policy Overview

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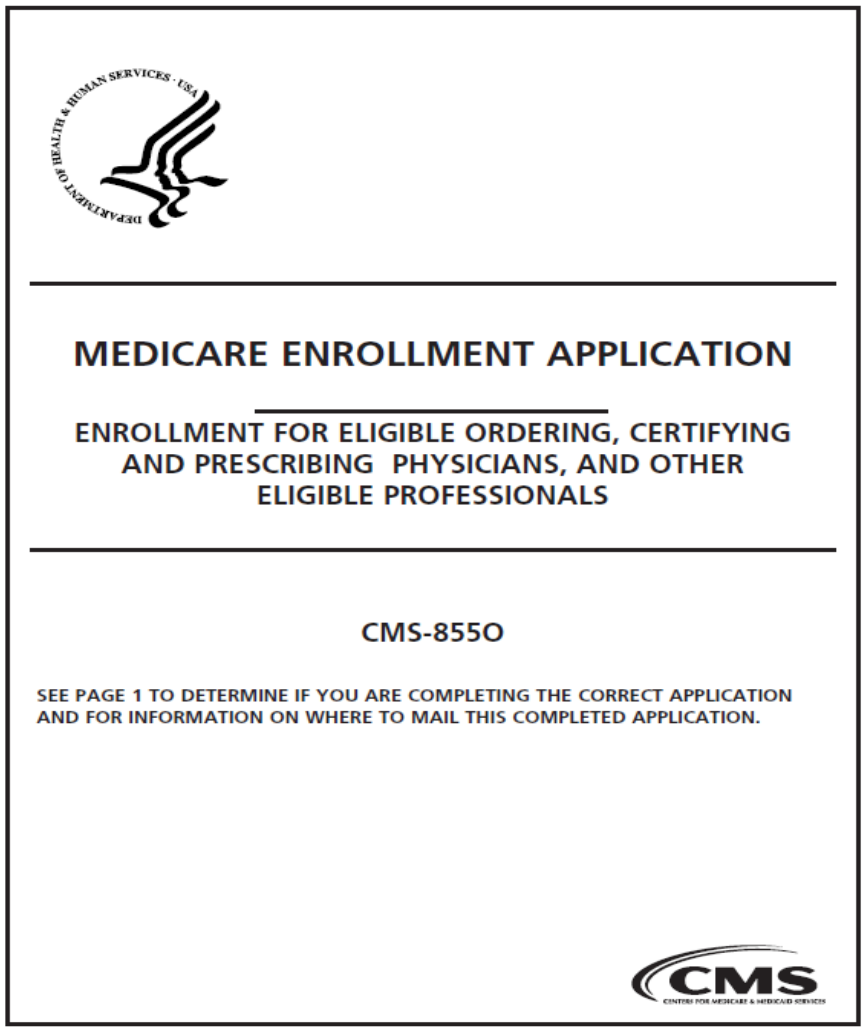
Session Overview

- Provide a comprehensive overview of how to enroll in Medicare solely to order, certify or prescribe via the CMS-855O and the PECOS equivalent
- Identify who is able to complete the CMS-855O
- Learn how to convert from ordering, certifying, prescribing only to a billing provider

CMS-855O Application



MEDICARE ENROLLMENT APPLICATION

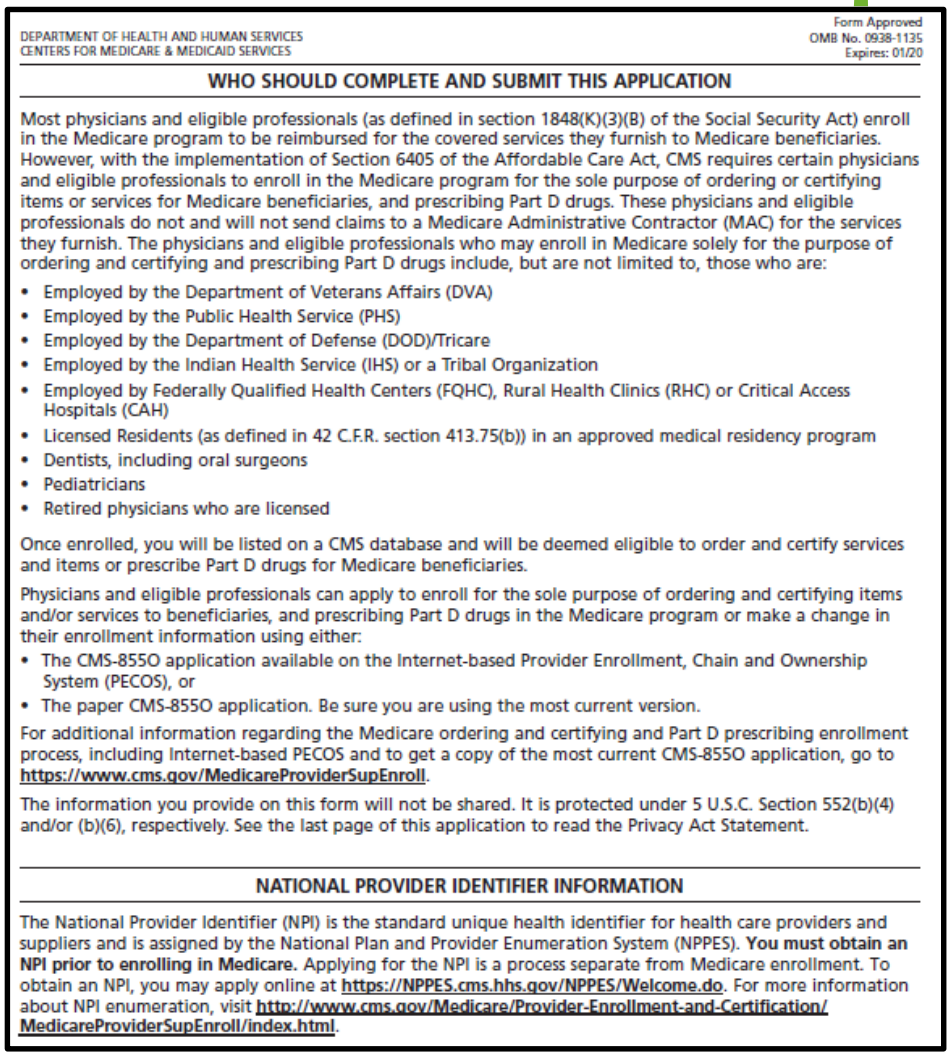
ENROLLMENT FOR ELIGIBLE ORDERING, CERTIFYING AND PRESCRIBING PHYSICIANS, AND OTHER ELIGIBLE PROFESSIONALS

CMS-855O

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION AND FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

- Used to enroll in Medicare solely to order or certify items and services or prescribe Part D drugs for Medicare beneficiaries
- Can submit the CMS-855O application via:
  - Internet-based PECOS
  - paper application
- Only one application is required (national enrollment)
- Enroll in the jurisdiction in which you are licensed

Who Should Complete this Application



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1135
Expires: 01/20

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

Most physicians and eligible professionals (as defined in section 1848(K)(3)(B) of the Social Security Act) enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS requires certain physicians and eligible professionals to enroll in the Medicare program for the sole purpose of ordering or certifying items or services for Medicare beneficiaries, and prescribing Part D drugs. These physicians and eligible professionals do not and will not send claims to a Medicare Administrative Contractor (MAC) for the services they furnish. The physicians and eligible professionals who may enroll in Medicare solely for the purpose of ordering and certifying and prescribing Part D drugs include, but are not limited to, those who are:

- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Public Health Service (PHS)
- Employed by the Department of Defense (DOD)/Tricare
- Employed by the Indian Health Service (IHS) or a Tribal Organization
- Employed by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or Critical Access Hospitals (CAH)
- Licensed Residents (as defined in 42 C.F.R. section 413.75(b)) in an approved medical residency program
- Dentists, including oral surgeons
- Pediatricians
- Retired physicians who are licensed

Once enrolled, you will be listed on a CMS database and will be deemed eligible to order and certify services and items or prescribe Part D drugs for Medicare beneficiaries.

Physicians and eligible professionals can apply to enroll for the sole purpose of ordering and certifying items and/or services to beneficiaries, and prescribing Part D drugs in the Medicare program or make a change in their enrollment information using either:

- The CMS-855O application available on the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855O application. Be sure you are using the most current version.

For additional information regarding the Medicare ordering and certifying and Part D prescribing enrollment process, including Internet-based PECOS and to get a copy of the most current CMS-855O application, go to https://www.cms.gov/MedicareProviderSupEnroll.

The information you provide on this form will not be shared. It is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. See the last page of this application to read the Privacy Act Statement.

NATIONAL PROVIDER IDENTIFIER INFORMATION

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **You must obtain an NPI prior to enrolling in Medicare.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at https://NPPES.cms.hhs.gov/NPPES/Welcome.do. For more information about NPI enumeration, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

- Physicians
  - Doctors of medicine or osteopathy
  - Doctors of dental surgery or dental medicine
  - Doctors of podiatry
  - Doctors of optometry
- Eligible Professionals
  - Physician assistants
  - Certified clinical nurse specialists
  - Nurse practitioners
  - Clinical psychologists
  - Certified nurse midwives
  - Clinical social workers

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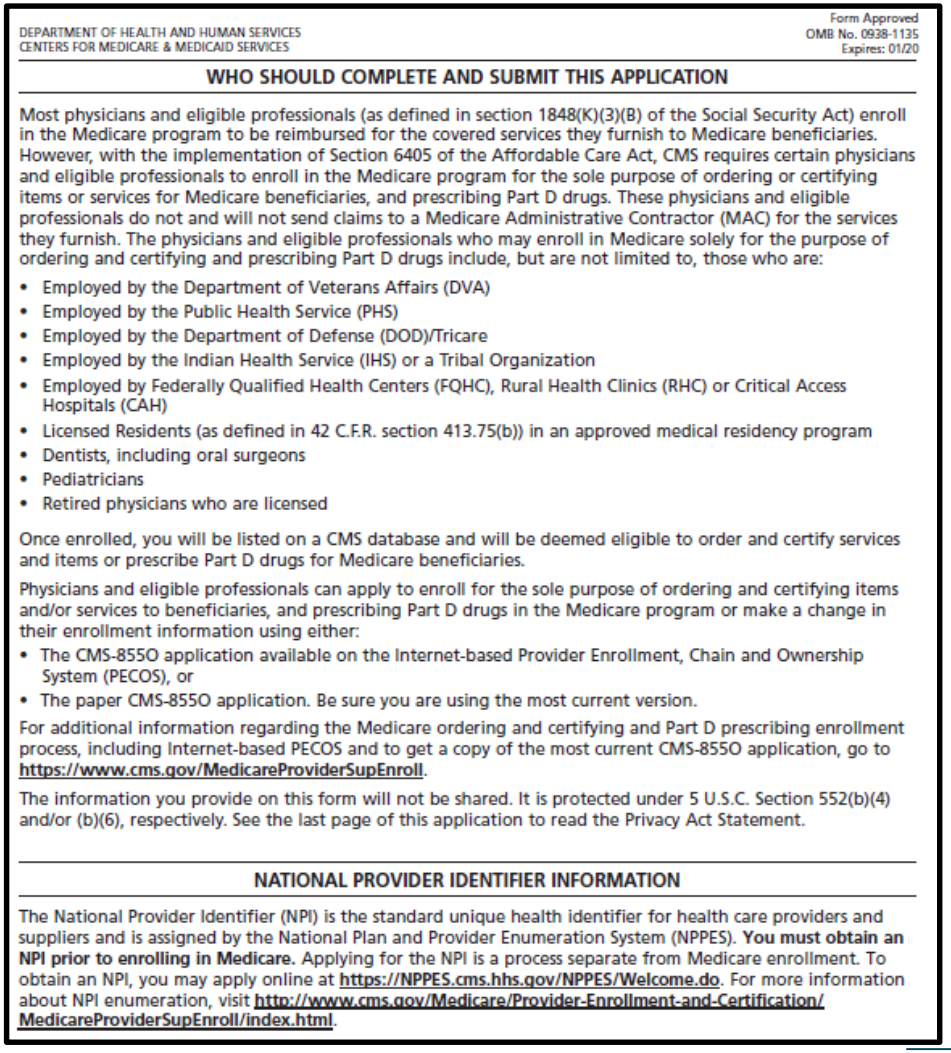
Who Should Complete this Application



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- Employed by the Department of Veterans Affairs (DVA)
- Employed by the Public Health Service (PHS)
- Employed by the Department of Defense (DOD)/Tricare
- Employed by the Indian Health Service (IHS) or a Tribal Organization
- Employed by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or Critical Access Hospitals (CAH)
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- Pediatricians
- Retired physicians who are licensed

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- Licensed residents
- Pediatricians
- Retired physicians who are licensed
- Employed by the DVA
- Employed by the PHS
- Employed by the DOD/Tricare
- Employed by the IHS or a Tribal Organization
- Employed by the FQHC, RHC or CAH

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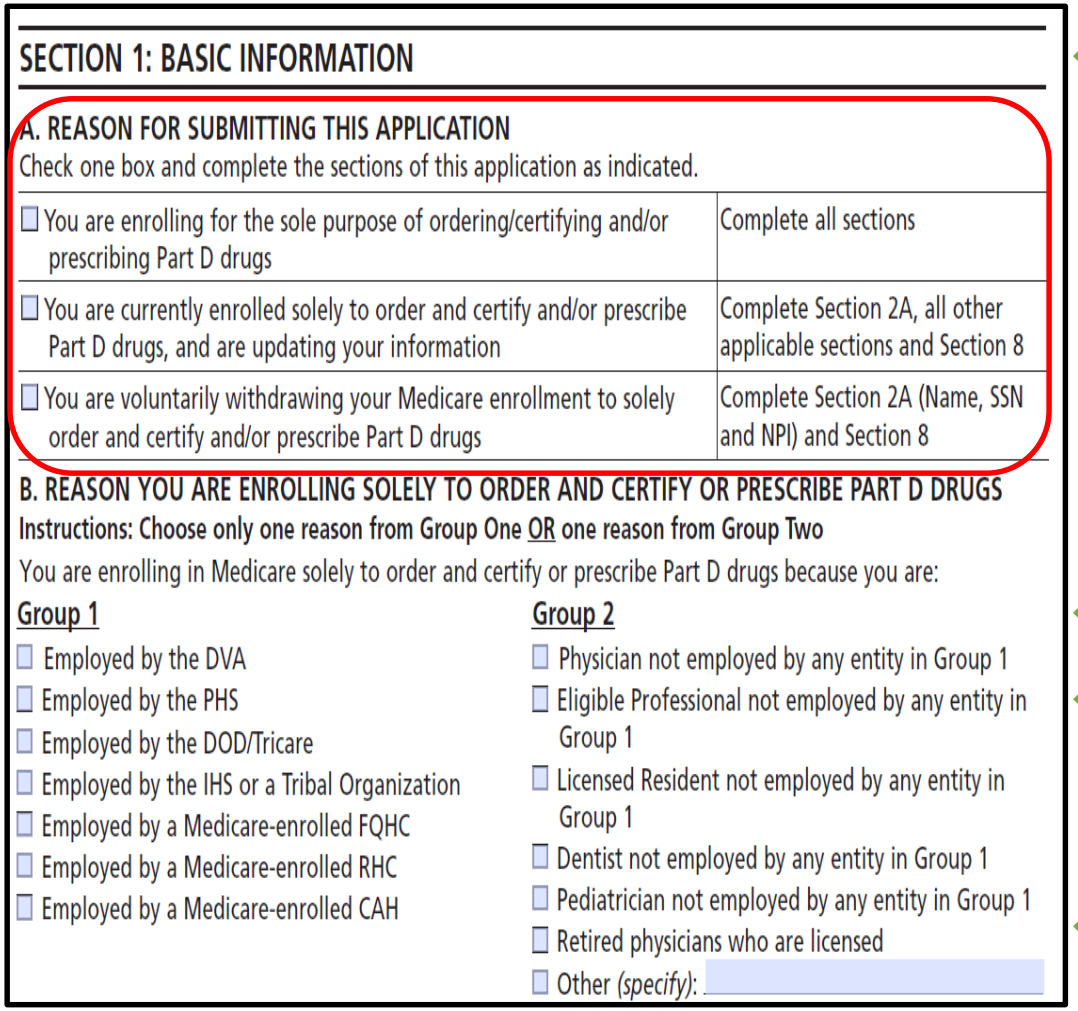
Section 1A & B - Reason for Submitting the CMS-855O



SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☐ You are enrolling for the sole purpose of ordering/certifying and/or prescribing Part D drugs	Complete all sections
☐ You are currently enrolled solely to order and certify and/or prescribe Part D drugs, and are updating your information	Complete Section 2A, all other applicable sections and Section 8
☐ You are voluntarily withdrawing your Medicare enrollment to solely order and certify and/or prescribe Part D drugs	Complete Section 2A (Name, SSN and NPI) and Section 8

B. REASON YOU ARE ENROLLING SOLELY TO ORDER AND CERTIFY OR PRESCRIBE PART D DRUGS

Instructions: Choose only one reason from Group One OR one reason from Group Two

You are enrolling in Medicare solely to order and certify or prescribe Part D drugs because you are:

Group 1

- ☐ Employed by the DVA
- ☐ Employed by the PHS
- ☐ Employed by the DOD/Tricare
- ☐ Employed by the IHS or a Tribal Organization
- ☐ Employed by a Medicare-enrolled FQHC
- ☐ Employed by a Medicare-enrolled RHC
- ☐ Employed by a Medicare-enrolled CAH

Group 2

- ☐ Physician not employed by any entity in Group 1
- ☐ Eligible Professional not employed by any entity in Group 1
- ☐ Licensed Resident not employed by any entity in Group 1
- ☐ Dentist not employed by any entity in Group 1
- ☐ Pediatrician not employed by any entity in Group 1
- ☐ Retired physicians who are licensed
- ☐ Other *(specify)*:

- Enroll solely to order or certify items and services
  - imaging and clinical laboratory services
  - durable medical equipment (DME)
  - home health services
- Prescribe Part D drugs
- Claims are not submitted to Medicare for services furnished
- Does not grant billing privileges

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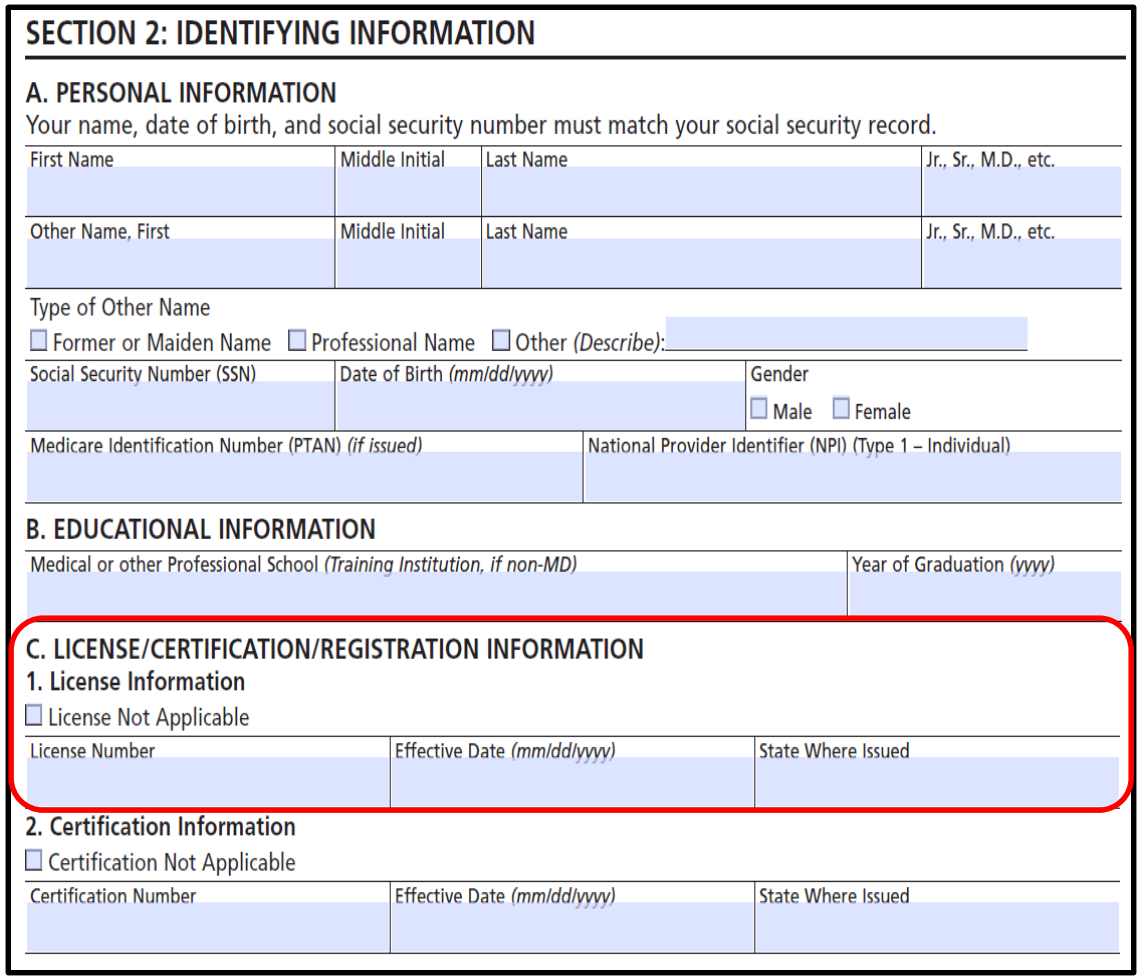
Section 2 - Identifying Information



SECTION 2: IDENTIFYING INFORMATION

A. PERSONAL INFORMATION

Your name, date of birth, and social security number must match your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., etc.

Type of Other Name

☐ Former or Maiden Name ☐ Professional Name ☐ Other *(Describe)*:

Social Security Number (SSN)	Date of Birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female

Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI) (Type 1 – Individual)

B. EDUCATIONAL INFORMATION

Medical or other Professional School *(Training Institution, if non-MD)*	Year of Graduation *(yyyy)*

C. LICENSE/CERTIFICATION/REGISTRATION INFORMATION

1. License Information

☐ License Not Applicable

License Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

2. Certification Information

☐ Certification Not Applicable

Certification Number	Effective Date *(mm/dd/yyyy)*	State Where Issued

- Must list legal name as it appears with the Social Security Administration
- Only need to be licensed in one State

Section 3 - Final Adverse Legal Actions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

A. CONVICTIONS

1. Any federal or state felony convictions (as defined in 42 C.F.R. section 1001.2) within the preceding 10 years.
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any past or current Medicare payment suspension under any Medicare and/or Medicaid billing number.
5. Any Medicare and/or Medicaid revocation of any Medicare and/or Medicaid billing numbers.

C. FINAL ADVERSE LEGAL ACTION HISTORY

If you are reporting a change in this section, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: _____

1. Have you, under any current or former name, ever had a final adverse legal action listed above imposed against you?

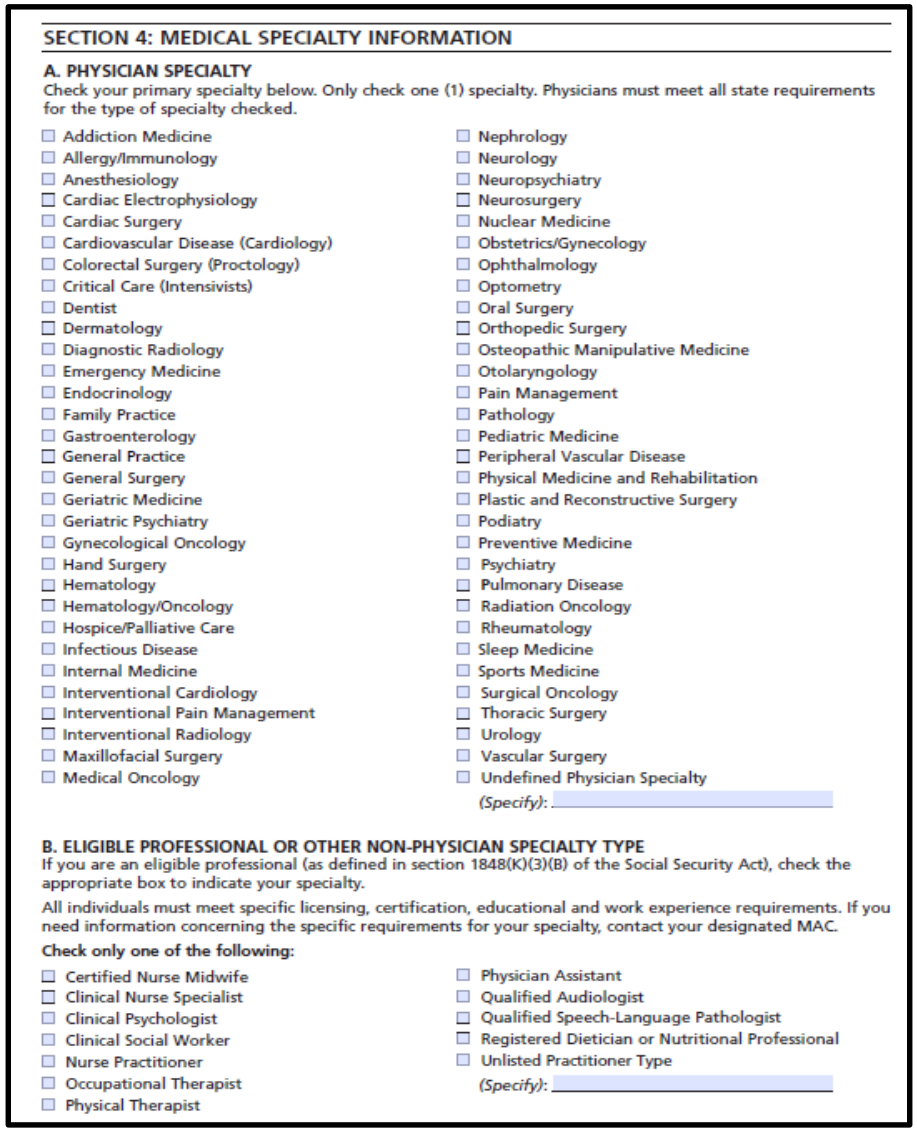
   ☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the federal or state agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final legal adverse action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 4 - Specialty Information



SECTION 4: MEDICAL SPECIALTY INFORMATION

A. PHYSICIAN SPECIALTY

Check your primary specialty below. Only check one (1) specialty. Physicians must meet all state requirements for the type of specialty checked.

- ☐ Addiction Medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dentist
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Practice
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice/Palliative Care
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Cardiology
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Specialty

(Specify): _____

B. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

If you are an eligible professional (as defined in section 1848(K)(3)(B) of the Social Security Act), check the appropriate box to indicate your specialty.

All individuals must meet specific licensing, certification, educational and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

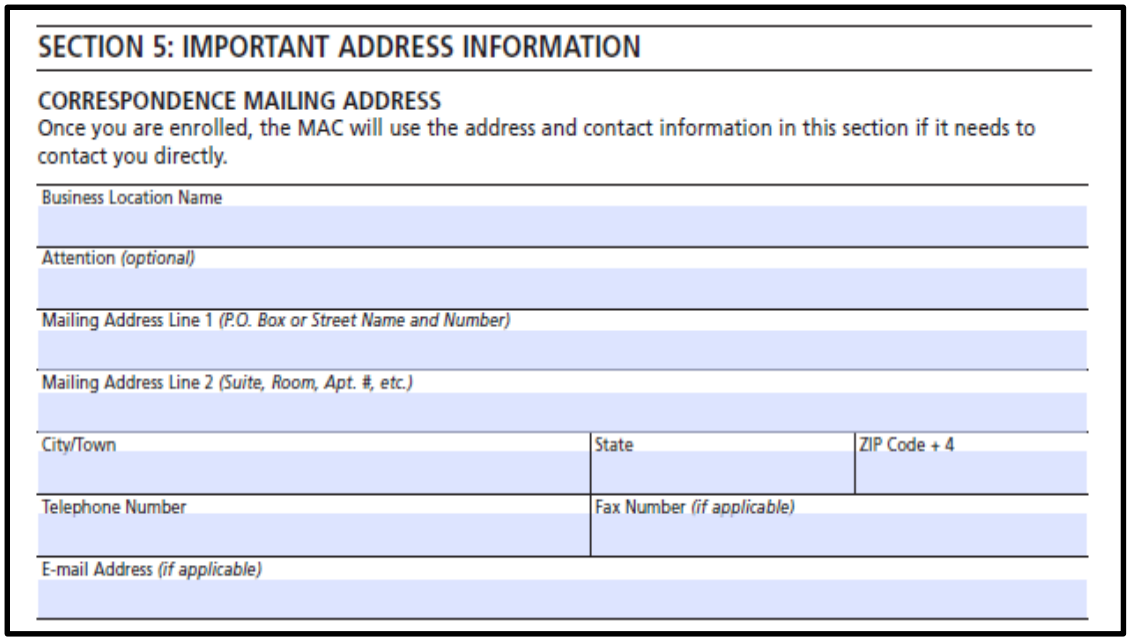
Check only one of the following:

- ☐ Certified Nurse Midwife
- ☐ Clinical Nurse Specialist
- ☐ Clinical Psychologist
- ☐ Clinical Social Worker
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Physician Assistant
- ☐ Qualified Audiologist
- ☐ Qualified Speech-Language Pathologist
- ☐ Registered Dietician or Nutritional Professional
- ☐ Unlisted Practitioner Type

(Specify): _____

- ❖ Select the appropriate specialty type
- ❖ Must be licensed and meet all state requirements for the specialty selected

Section 5 - Correspondence Address



SECTION 5: IMPORTANT ADDRESS INFORMATION

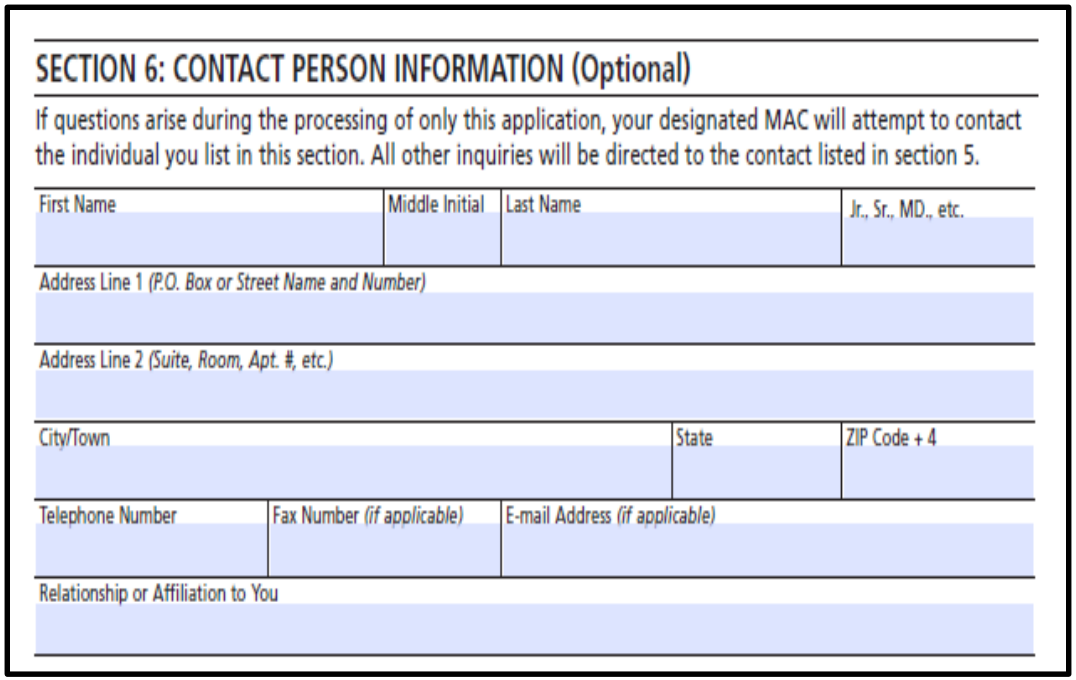
CORRESPONDENCE MAILING ADDRESS

Once you are enrolled, the MAC will use the address and contact information in this section if it needs to contact you directly.

Business Location Name		
Attention *(optional)*		
Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	
E-mail Address *(if applicable)*		

- List address where MAC can contact you directly
- It cannot be the address of a billing agency, management services organization, or the provider's representative (e.g., attorney, financial advisor)
- It can be the provider's home address

Section 6 - Contact Person



SECTION 6: CONTACT PERSON INFORMATION (Optional)

If questions arise during the processing of only this application, your designated MAC will attempt to contact the individual you list in this section. All other inquiries will be directed to the contact listed in section 5.

First Name	Middle Initial	Last Name	Jr., Sr., MD., etc.

Address Line 1 *(P.O. Box or Street Name and Number)*

Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Relationship or Affiliation to You

- Contact person is optional
  - MACs will use if additional information is needed
  - Will receive development requests and approval notification
- If no contact is listed the MAC will contact the provider directly

Section 7 – Penalties for Falsifying Information

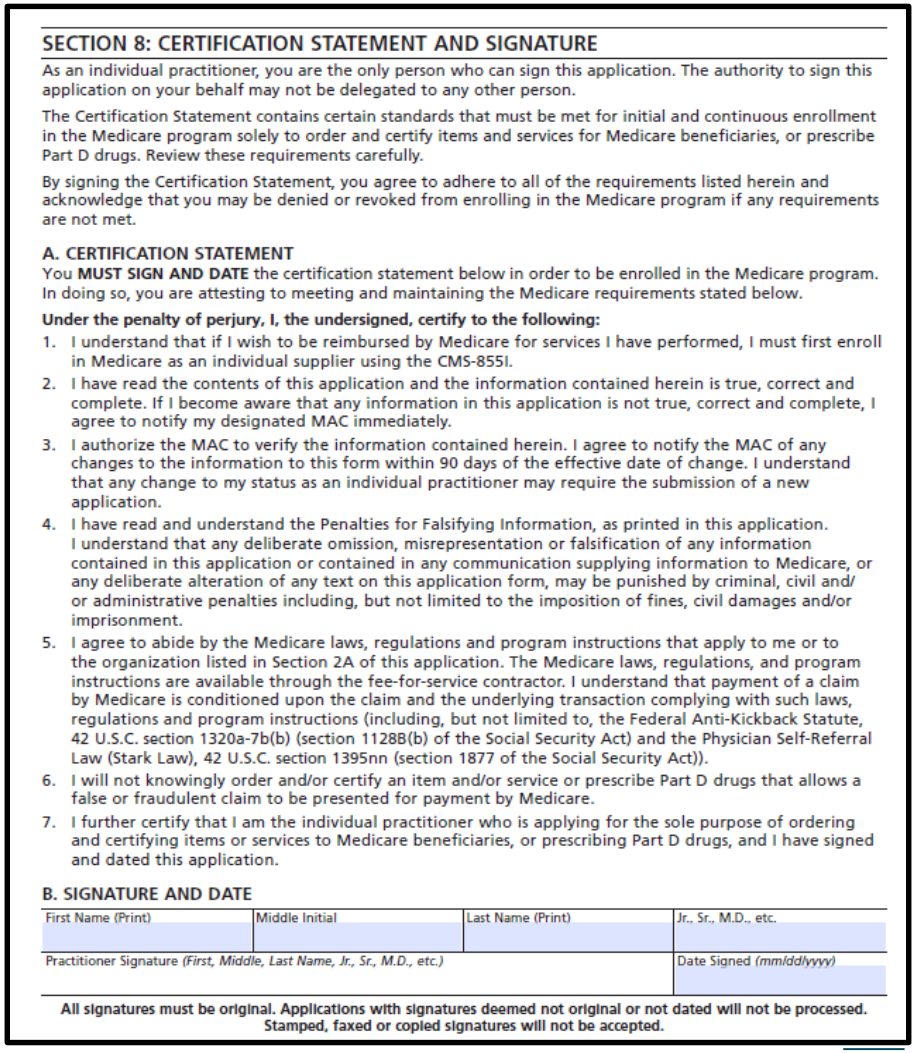
SECTION 7: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. section 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…a claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.
5. This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.
6. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
7. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both.

Section 8 - Certification Statement



SECTION 8: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign this application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program solely to order and certify items and services for Medicare beneficiaries, or prescribe Part D drugs. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed herein and acknowledge that you may be denied or revoked from enrolling in the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I understand that if I wish to be reimbursed by Medicare for services I have performed, I must first enroll in Medicare as an individual supplier using the CMS-855I.
2. I have read the contents of this application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct and complete, I agree to notify my designated MAC immediately.
3. I authorize the MAC to verify the information contained herein. I agree to notify the MAC of any changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application.
4. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil and/or administrative penalties including, but not limited to the imposition of fines, civil damages and/or imprisonment.
5. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 2A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
6. I will not knowingly order and/or certify an item and/or service or prescribe Part D drugs that allows a false or fraudulent claim to be presented for payment by Medicare.
7. I further certify that I am the individual practitioner who is applying for the sole purpose of ordering and certifying items or services to Medicare beneficiaries, or prescribing Part D drugs, and I have signed and dated this application.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

- Only the individual physician or eligible professional can sign
- Must print, sign and date
  - Stamped, faxed or copied signatures are not accepted

Ordering, Certifying File

- Validate your ordering and certifying status via data.cms.gov
- CMS posts files of physicians and eligible professionals who are eligible to order or certify:
  - Ordering and Certifying File – lists the names and National Provider Identifiers (NPIs) of eligible physicians and professionals

Convert to a Billing Provider

What if I am approved to order, certify or prescribe and later wish to obtain Medicare billing privileges?

- Easiest way to convert your enrollment is through Internet-based PECOS
  - PECOS will display your existing approved enrollments and use the information to pre-populate the new application
  - Provider enters the missing information to complete the enrollment
  - You must confirm that you want to convert the existing enrollment before the new application can be submitted

Convert to a Billing Provider (cont.)

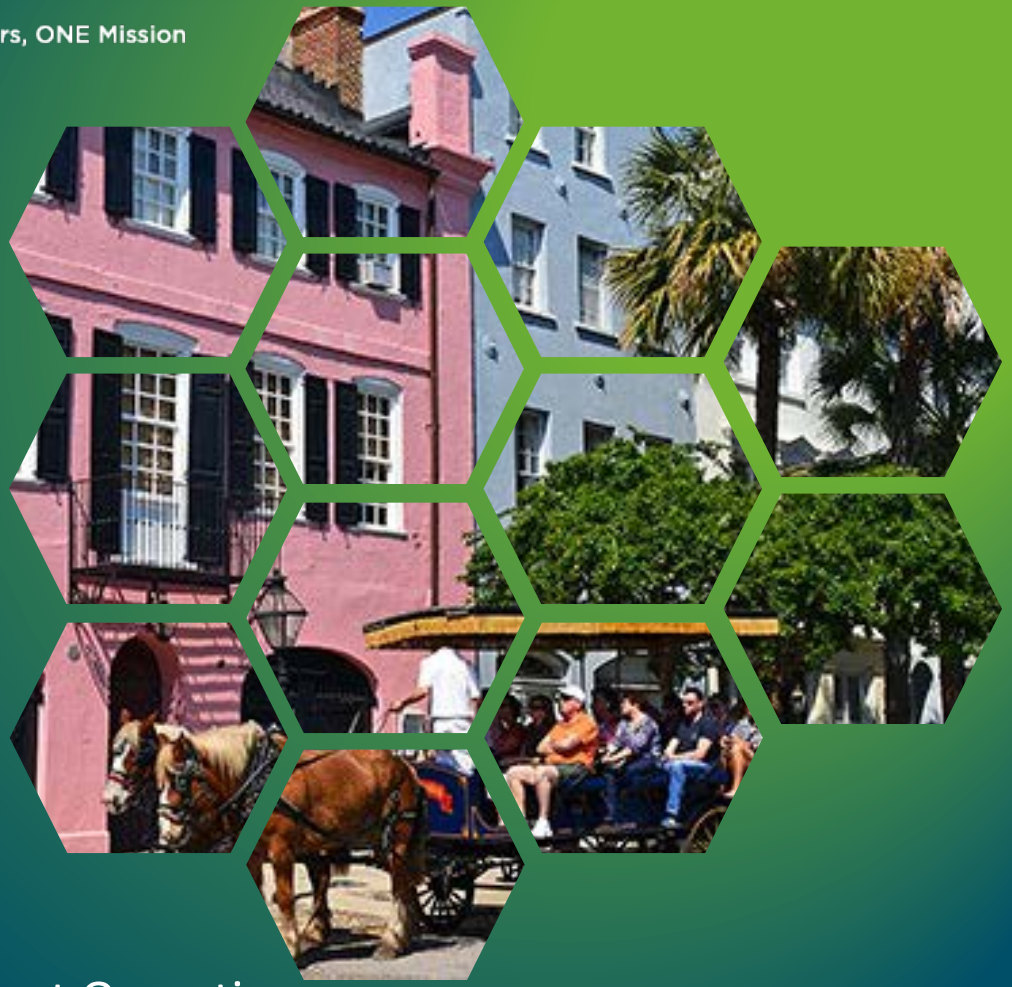
- If submitting via paper
  - Submit a complete CMS-855I application to your MAC
  - The MAC will voluntarily withdraw the CMS-855O enrollment
- As a billing provider you also have the ability to order, certify and prescribe if you are of a specialty type that can perform those services

Resources

- SE1305 – Ordering and certifying requirements
- SE1434 – Prescriber enrollment requirements
- Medicare Provider-Supplier Enrollment website
- Medicare Program Integrity Manual – Chapter 15, section 15.16

NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission



Opt-Out Policy Overview

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Session Overview

- What it means to opt-out
- Who can opt-out
- How to properly opt-out
- The impacts of opting-out

Opt-Out of Medicare

- Physicians/practitioners who do not wish to enroll in the Medicare program may “opt-out”
- What this means:
  - The physician/practitioner nor the beneficiary submits a bill and is reimbursed by Medicare for services rendered (beneficiary pays out-of-pocket)
  - A private contract is signed between the physician/practitioner and the beneficiary
  - The physician/practitioner submits an affidavit to Medicare to opt-out of the program

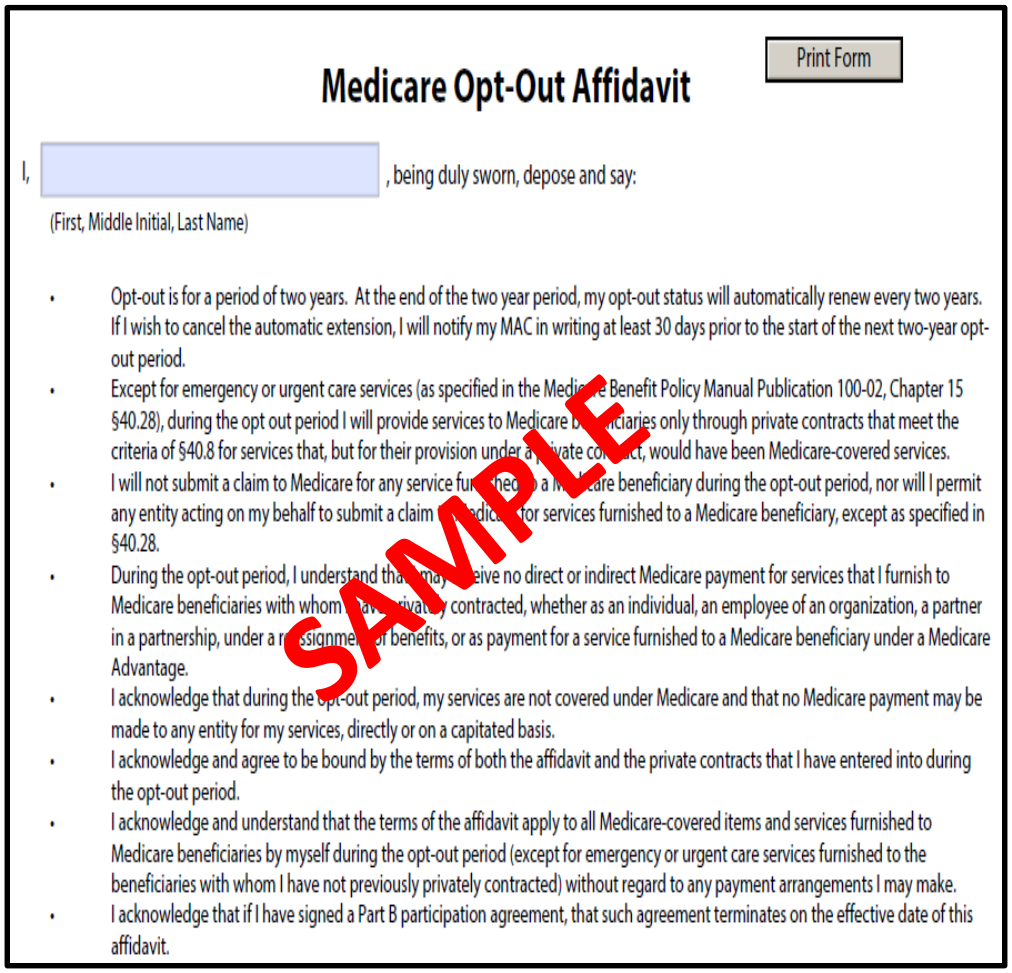
Who Can Opt-Out

- **Physicians:**
  - Doctors of medicine or osteopathy
  - Doctors of dental surgery or dental medicine
  - Doctors of podiatry
  - Doctors of optometry
- **Non Physician Practitioners:**
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified registered nurse anesthetists
  - Certified nurse midwives
  - Clinical psychologists
  - Clinical social workers
  - Registered dietitians
  - Nutrition professionals

Requirements of a Private Contract

- Must be in writing and signed by beneficiary and the physician/practitioner
- Identify whether the physician/practitioner is excluded from Medicare
- Beneficiary accepts full responsibility for payment of all services furnished by the physician/practitioner
- Beneficiary agrees not to submit a claim to Medicare or to ask the physician/practitioner to submit the claim
- Beneficiary is aware that they have the right to obtain Medicare-covered items and services from physicians/practitioners who have not opted out of Medicare
- Be made available to CMS upon request

Filing an Opt-Out Affidavit



Print Form

Medicare Opt-Out Affidavit

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

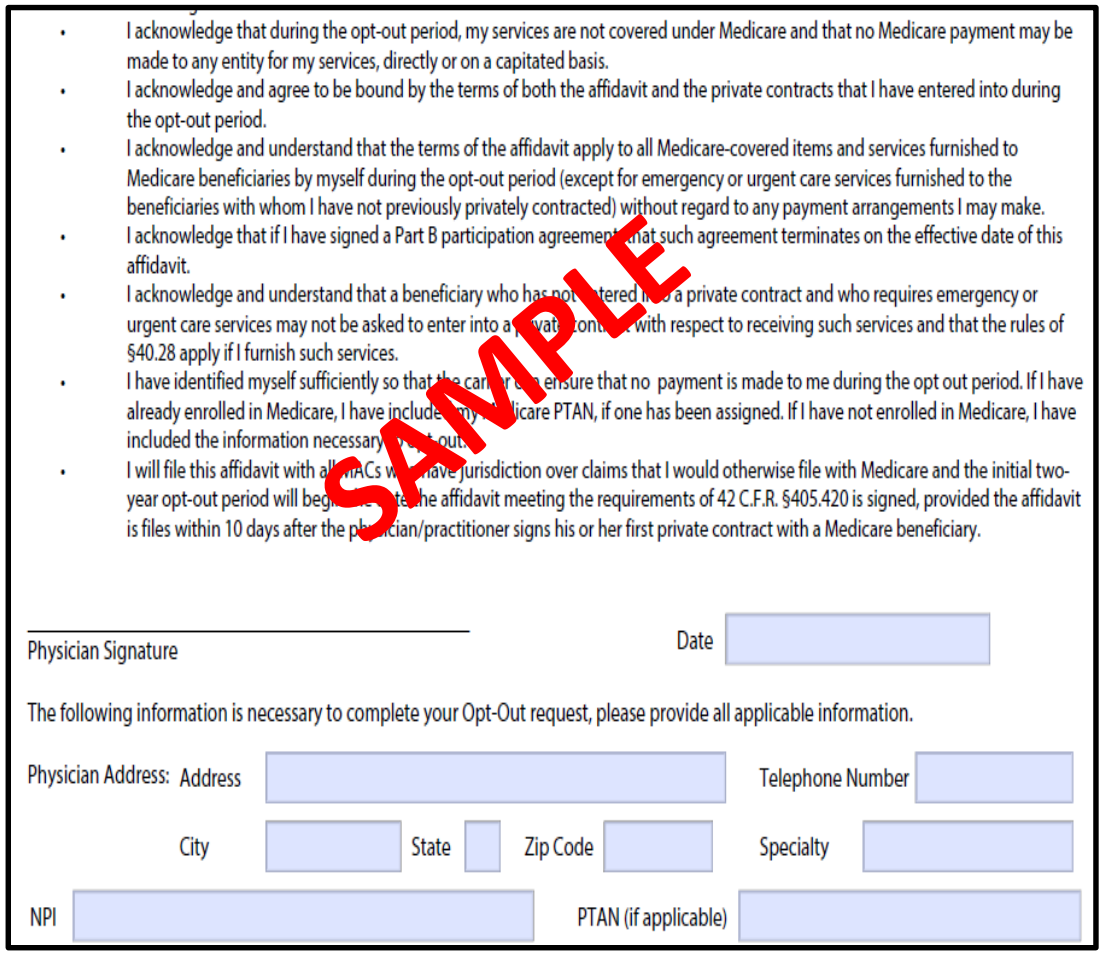
(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew every two years. If I wish to cancel the automatic extension, I will notify my 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 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.

SAMPLE

- A standard CMS form is not available
- Some MACs have a form available on their website
- Must be filed with all MACs who have jurisdiction over the claims the physician/ practitioner would have otherwise filed with Medicare

Filing an Opt-Out Affidavit



- 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 MACs who have jurisdiction over claims that I would otherwise file with Medicare and the initial two-year opt-out period will begin on the date the affidavit meeting the requirements of 42 C.F.R. §405.420 is signed, provided the affidavit is files within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

SAMPLE

Physician Signature _____ Date _____

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) _____

- Must include identifying information:
  - Legal name
  - Medicare specialty
  - Social Security Number
  - Address
  - Telephone number
  - PTAN (if assigned)
  - NPI
- Must be signed by the physician/practitioner

Filing an Opt-Out Affidavit

- It must include various statements to which the physician/practitioner must agree; for example:
  - Will only provide services to Medicare beneficiaries through private contracts
  - Will not submit claims to Medicare for any services furnished, except for emergency or urgent care services
  - May not receive direct or indirect Medicare payment for services that are furnished to Medicare beneficiaries
  - Identify the physician/practitioner sufficiently so that the MAC can ensure that no payment is made during the opt-out period

Effective Date of an Opt-Out Affidavit

- Affidavit must be filed no later than 10 days after entering into the first private contract with a Medicare beneficiary
- Opt-out period last for 2 years and begins the date the affidavit is signed
- Affidavits signed on or after June 16, 2015 will automatically renew every two years
  - Physicians/practitioners are no longer required to file renewal affidavits to continue their opt-out status

Terminating Opt-Out Affidavit

- Cannot terminate early unless opting out for the first time and within 90 days after the effective date of the opt-out period
- At the end of the 2 year period you can cancel by notifying all MACs in writing at least 30 days prior to the start of the next opt-out period

Impacts of Opting-Out

- May not receive direct or indirect Medicare payment for services furnished to Medicare beneficiaries
  - Traditional Medicare fee-for- service
  - Under a Medicare Advantage plan
- May order or certify items and services or prescribe Part D drugs for Medicare beneficiaries
  - NPI
  - Date of Birth
  - Social Security Number
  - Confirmation if an Office of Inspector General (OIG) exclusion exists

Resources

- SE1311 - Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries
- Medicare Program Integrity Manual - Chapter 15, section 15.14.7