PROPOSAL: A physician may choose not to enroll in Medicare.

Individual physicians often ask about their options with respect to Medicare, particularly given the uncertainty of Congressional action on the Sustainable Growth Rate (SGR) as well as many uncertainties related to the Patient Protection and Affordable Care Act (PPACA).

An individual physician has four possible relationships with Medicare:

(i) An enrolled[1] and *participating* physician agrees to bill Medicare for all services provided to Medicare beneficiaries, accepts assignment of patients' Medicare benefits, and accepts amounts allowed by Medicare as payment in full for medically necessary, covered services as defined by Medicare. A physician typically receives 80% of Medicare's allowed amounts.

(ii) An enrolled and *non-participating* physician also agrees to bill Medicare for all services provided to Medicare beneficiaries, may choose to either accept assignment or not accept assignment of patients' Medicare benefits, and accepts amounts allowed by Medicare as payment in full for medically necessary, covered services as defined by Medicare.[2] The payments that a non-participating physician may collect from patients at the time of service are 9% higher than the regulated prices Medicare allows a participating physician to charge.

(iii) An enrolled physician who then chooses to *opt out* agrees not to bill Medicare for two years, is not limited to any fee schedule and further agrees to require his/her patients to forfeit Medicare benefits and instead pay mutually agreeable fees directly to the physician.[3]

---

[1] Sec. 1802. [42 U.S.C. 1395a] FREE CHOICE BY PATIENT. (a) Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person *qualified to participate* under this subchapter if such institution, agency, or person undertakes to provide him such services.
Sec. 1866. [42 U.S.C. 1395cc] (a)(1): AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES "(1) Any *provider* of services (except a fund designated for purposes of section 1395f (g) and section 1395n (e) of this title) *shall be qualified to **participate*** under this subchapter (Medicare) and shall be eligible for payments under this subchapter ***if** it files with the Secretary an agreement*…" (Emphasis added)

[2] The United States Court of Appeal for the Second Circuit in *Garelick v. Sullivan* (2d Cir. 1993) 987 F.2d 913 addressed anesthesiologists' payment options who claimed they were compelled to treat Medicare beneficiaries and who *submitted bills to Medicare* as non-participating physicians. The Court rejected a constitutional challenge to the limiting charge provision, holding that there was no "taking" prohibited by the Fifth Amendment of the United States Constitution. In reaching its holding, the court reasoned that physicians are under no legal duty to provide services to the elderly and to submit to price regulations. This holding did not address the circumstance where a physician does not enroll in Medicare, does not submit to price regulations, and does not bill Medicare. This holding also does not address the circumstance where a beneficiary pays a physician and seeks reimbursement from Medicare after refusing to permit the physician to bill Medicare.

[3] Sec. 1802. [42 U.S.C. 1395a] describes opt-out contracts. Claims that § 1395a violates several Amendments to the Constitution, as well as the Spending Clause of Article I, section 8 of both physicians and the Medicare beneficiaries who voluntarily enter into opt-out contracts were dismissed by an appellate court: http://law.justia.com/cases/federal/appellate-courts/F3/182/965/627467/

DRAFT

(iv) A physician who chooses *not to enroll* is not entitled to bill Medicare at all; a patient may seek reimbursement directly from Medicare after paying the physician a mutually agreeable fee. Medicare may or may not reimburse the beneficiary. Unlike patients who seek medical care from a physician who opts out, patients typically do not lose Medicare benefits when they receive medical care from a physician who chooses not to enroll in Medicare.

Information regarding the first three physician relationships with Medicare - participating, non-participating, and opted out - is available in CMA's ON-CALL Document #0151 (January 2011).

This document discusses the fourth relationship – un-enrolled status.

There is nothing in the Medicare law that requires a physician to enroll.

1. **Why do many physicians decide to enroll in Medicare?**

   Many physicians enroll in Medicare because they want to bill Medicare instead of their patients. For instance, some physicians who provide emergent care have difficulty collecting payments from their patients.

   Many physicians have contracts with entities such as some hospital medical staffs and Medicare Advantage that require Medicare enrollment.

   Arguably, the essential reason that most physicians bill Medicare is simply because nearly *everyone has done so* for decades. It is perfectly understandable why virtually all physicians enrolled in Medicare for the first twenty years given its substantial economic benefits during that period; but times have changed.

2. **Is every physician required to enroll in Medicare?**

   No. (See below.)

   Medicare Part B physician enrollment is a process whereby a physician becomes eligible to *submit claims for payment to Medicare*. In return for the privilege to bill Medicare and to receive payments *from Medicare*, an enrolled physician agrees to accept Medicare's fee schedule as payment in full.[4] See the attestation on form CMS-855i ("Medicare Enrollment Application for Physicians and Non-Physician Practitioners"), Section 15, number 9 that clarifies the purpose of Medicare enrollment: "I further certify that I am the individual practitioner who is *applying for Medicare billing privileges*." (Emphasis added)

[4] 42 C.F.R. § 424.505: "To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier ***must be enrolled*** in the Medicare program. Once enrolled, the provider or supplier receives ***billing privileges*** and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered." (Emphasis added)

3. Why do some physicians choose not to enroll in Medicare?

Some physicians, for instance pediatricians and pediatric specialists, rarely provide medical care to Medicare beneficiaries.

Some physicians want to protect their patients' privacy. For instance, many psychiatrists consider production of medical records for third party review an unethical breach of patient confidentiality. Since Medicare reserves the right to review medical records of physicians enrolled in the system, some physicians choose not to enroll in Medicare.

Some physicians do not want their patients to lose their Medicare Part B benefits when seeing them. A patient forfeits these benefits if an *enrolled* physician *opts out* of Medicare Part B in accordance with the narrow provisions of Sec. 1802. [42 U.S.C. 1395a] but does not forfeit these benefits if his/her physician chooses *not to enroll* in Medicare.

Some physicians want to give patients the extra time and attention they need through home visits and other special services.

Some physicians cannot enroll in Medicare in a timely manner. In order to provide medical care during a protracted enrollment process, some physicians bill their patients and then assist these patients to seek reimbursement directly from Medicare.

Some foreign physicians provide care to Medicare beneficiaries who travel internationally.

Some physicians cannot stay in business if they accept Medicare's regulated prices as payment in full. These physicians choose not to enroll in Medicare so that they can collect their professional fees in an egalitarian manner, without respect to age. They are also able to provide appropriate discounts to those in need without running afoul of Federal law and Medicare regulations. Access to care is improved since physicians are able to keep their practices viable.

Some physicians fear threats of felony charges, civil monetary penalties, and RACs (recovery audits) that sometimes compel enrolled physicians to comply with Medicare's coding and billing rules even when these rules jeopardize patients.

Physicians employed by the Department of Veterans Affairs, Public Health Service, Department of Defense, or by Medicare enrolled Federally Qualified Health Centers, Rural Health Clinics, or Critical Access Hospitals do not enroll in Medicare.

Physicians in fellowship programs do not enroll in Medicare.

DRAFT

PROPOSAL: A PHYSICIAN MAY CHOOSE NOT TO ENROLL IN MEDICARE

4. **Is a physician who chooses not to enroll qualified to submit bills to Medicare for any non-emergent services?**

   No.

5. **Is a physician who chooses not to enroll permitted to submit bills to Medicare for emergent services?**

   Yes.

   Complete form CMS-1500 and submit it to Medicare. Write on the form, "Emergent services. Dr. _____ is not enrolling in Medicare." It is possible that such a claim submission will trigger Medicare to try to begin the enrollment process (Medicare Benefit Policy Manual, Section 40.13: https://www.cms.gov/manuals/Downloads/bp102c15.pdf)

6. **May a physician who chooses not to enroll in Medicare provide medical care to a Medicare beneficiary and collect a mutually agreeable fee?**

   Yes.

   A physician who chooses not to enroll in Medicare Part B does not have any obligation to Medicare.

7. **Will Medicare reimburse a beneficiary who pays for covered medical services provided by a physician who chooses not to enroll in Medicare?**

   Yes.[5]

   In order to receive reimbursement from Medicare, a patient must complete form CMS-1490S, write on form CMS-1490S, "My physician is not enrolled in Medicare," and send the completed

[5] "If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or ***refuses to enroll*** in the Medicare program, the beneficiary should: (1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or ***refused to enroll*** in Medicare, and (2) Submit a complete Form CMS-1490S with all supporting documentation. The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's ***refusal*** or inability to submit the claim and/or ***enroll*** in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message." Medicare Claims Processing Manual, Disposition, Sec.2 (Approx. Page 203) http://www.cms.gov/manuals/downloads/clm104c01.pdf (Emphasis added.)

form to the local Medicare intermediary. When form CMS-1490S is used, an itemized bill must be submitted with the claim. "Inasmuch as form CMS-1490S has no provision for an ICD-9 code, the ICD-9 code is not required at the time of claim submission."[6] (Section 70.8.4, Medicare Claims Processing Manual). Further, there is no provision for use of CPT codes.

Download form CMS-1490S at: https://www.cms.gov/cmsforms/downloads/cms1490S-english.pdf. In California,[7] send completed forms CMS-1490S to:

J1 MAC-Palmetto GBA
P.O Box 1051Augusta
Georgia 30903

Medicare will typically forward a CMS 1490S claim to the beneficiary's supplemental insurer. If Medicare does not forward a claim, the beneficiary may complete form CMS-1500 and send it to their supplemental insurer, which may also reimburse the beneficiary.

8. How much will Medicare reimburse a beneficiary for services performed by a physician who chooses not to enroll in Medicare?

Medicare contractors typically pay Medicare's allowable amount if the claim is for a service that would be payable by Medicare were it submitted by a physician enrolled in Medicare. (Medicare Claims Processing Manual, section 70.8.8.6: http://www.cms.gov/manuals/downloads/clm104c01.pdf

Endnotes One[i] is an EOB[8] sent to a patient who paid an un-enrolled physician at the time of service and then submitted form CMS-1490S to Medicare for reimbursement. Medicare sometimes forwards such claims to any supplemental insurer on behalf of a beneficiary, although in this circumstance the patient submitted form CMS-1500 to a supplemental insurer (United Behavioral Health) and received additional reimbursement. See Endnote Two.[ii]

9. May a physician who is not enrolled in Medicare refer Medicare beneficiaries for other services such as laboratory tests?

Yes.

[6] The American Medicare Association earns significant non-dues revenue from its CPT Code copyright.

[7] Address list: http://www.medicare.gov/navigation/medicare-basics/understanding-claims/how-to-file-a-claim.aspx.

[8] Although this Medicare EOB claims that a physician who chooses not to enroll in Medicare part B is prohibited from billing the beneficiary more than the Medicare allowed amount, Medicare manuals do not describe penalties or recommend referral to the Office of the Inspector General if a physician charges exceed the amount allowed by Medicare.

PROPOSAL: A PHYSICIAN MAY CHOOSE NOT TO ENROLL IN MEDICARE

10. Will Medicare pay for services ordered by a physician who chooses not to enroll in Medicare?

Yes.

A patient who seeks care from a physician who chooses not to enroll in Medicare does not forfeit Medicare benefits, but may give up the convenience of having a third party bill for services ordered by an un-enrolled physician.

There are two ways that a performing facility such as a laboratory or radiology facility might get paid for services ordered by a physician who chooses not to enroll in Medicare.

First, section 6405 of the Affordable Care Act requires that any physician who wishes to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries must complete the following sections of form CMS-855i:

- Section 1 (basic information)
- Section 2 (identifying information)
- Section 3 (final adverse actions/convictions)
- Section 13 (contact person)
- Section 15 (certification statement)

Download form CMS-855i at: www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf. The physician MUST include a cover letter with this enrollment application stating that s/he is enrolling in Medicare for the sole purpose of ordering and referring items or services for a Medicare beneficiary.[9] Mail the completed enrollment application with a letter to the Medicare enrollment contractor:
http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

Alternatively, a physician who chooses not to enroll in Medicare may suggest the patient select Option Two on an Advance Beneficiary Notice (ABN)[10] asking the facility performing a service not to bill Medicare but instead to bill the patient personally.

The Medicare beneficiary may then seek reimbursement directly from Medicare by submitting form CMS-1490S with a letter explaining that the service was ordered by a physician who chooses not to enroll in Medicare.

A physician who is not enrolled in Medicare may wish to give form CMS-1490S along with an explanatory letter to a patient who is referred for services. The referring physician might complete the form for the patient to approve and sign and provide an addressed envelope for the convenience of both the patient and the facility performing the requested study.

[9] For more information: http://www.cms.gov/MLNMattersArticles/downloads/MM7097.pdf , https://www.cms.gov/MedicareProviderSupEnroll/Downloads/SpecialEnrollmentFactsheetInfrequentPhysicianReimbursement.pdf, http://www.cms.gov/manuals/downloads/pim83c15.pdf or https://www.cms.gov/transmittals/downloads/R355PI.pdf

[10] Advanced Beneficiary Notice: http://www.advancebeneficiarynotice.net/downloads/Form%20CMS-R-131.pdf

DRAFT

PROPOSAL: A PHYSICIAN MAY CHOOSE NOT TO ENROLL IN MEDICARE

11. May a physician who is currently enrolled in Medicare as a participating provider or a non-participating provider choose to un-enroll?

Yes.

Complete the following sections of form CMS-855i:

- Section 1A (basic information)
- Section 13 (contact person)
- Section 15 (certification statement)

In Section 1, under "REASON FOR APPLICATION," check the box that states, "You are voluntarily terminating your Medicare enrollment."

12. May an enrolled physician who has opted out of Medicare choose to un-enroll?

Yes.

Complete the following sections of form CMS-855i:

- Section 1A (basic information)
- Section 13 (contact person)
- Section 15 (certification statement)

In Section 1, under "REASON FOR APPLICATION," check the box that states, "You are voluntarily terminating your Medicare enrollment."

13. Is a young physician or immigrant physician entering private practice required to enroll in Medicare?

No.

A physician who does not want to enroll in Medicare, i.e. does not want to bill Medicare for services provided to Medicare beneficiaries (either as assigned or un-assigned claims for payment), does not have to complete form CMS-855i.

14. Is a physician who is currently enrolled in Medicare required to re-enroll?

No.

A physician who decides not to submit any more bills to Medicare does not need to re-enroll. New Medicare rules will require every physician who wishes to continue to submit bills to Medicare (both assigned and unassigned claims) to re-enroll periodically.

DRAFT

If a physician does not re-enroll, Medicare will revoke his/her billing privileges. Although Medicare typically reimburses its beneficiaries for services provided by a physician whose billing privileges have been revoked, it might be preferable for a physician to resign by completing the relevant sections of CMS-855i. (Medicare does not reimburse its beneficiaries for medical care provided by a physician who has been sanctioned or excluded from Medicare for things like fraud.)

15. Is a physician who is not enrolled in Medicare and is therefore not qualified to bill Medicare *obligated* to require his/her patients to sign opt-out contracts?

No.[11]

Physicians who choose not to enroll in Medicare are *not prohibited* - but also are *not obligated* - to opt out of Medicare. See Sec. 1802. [42 U.S.C. 1395a (b)]: "Use of Private Contracts by Medicare Beneficiaries.—(1) In general.—Subject to the provisions of this subsection, nothing in this title ***shall prohibit*** a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service…"

Be aware that an un-enrolled physician who also opts out simply forces his or her patients to forfeit all Medicare Part B benefits for the physician's medical care.

16. Do the Social Security Act Amendments of 1994 apply to a physician who chooses not to enroll in Medicare?

No.

There is no law requiring every physician to both bill Medicare and accept payments from it because the U. S. Constitution, including Amendment 13, as well as Sec. 1802. [42 U.S.C. 1395a], does not grant authority to the federal government to require every physician to serve it.

The Social Security Amendments of 1994 only apply to *physicians who bill Medicare*. In order for either a physician or a patient to receive payment from Medicare for a bill submitted by a physician, the physician must voluntarily *enroll* in Medicare. See Code of Federal Regulations (CFR) title 42, part 424, section 505 (42 C.F.R. 424.505) § 424.505:

[11] Sec. 1802. [42 U.S.C. 1395a] PROHIBITION AGAINST ANY FEDERAL INTERFERENCE "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

> "Basic enrollment requirement. To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a *provider* or supplier *must be enrolled* in the Medicare program."

A physician who chooses not to enroll in Medicare does not submit bills to Medicare or receive payments from Medicare. Before the issue of "participating" or "non-participating" is reached a physician must have already voluntarily ***enrolled***.

To be clear, there are two general categories of physicians:

1. Those who ***choose not to enroll*** in Medicare Part B and therefore are ***forbidden to submit claims*** to Medicare or ***receive payments*** from Medicare (except for emergency services).
2. Those who ***choose to enroll*** in Medicare Part B and are ***required to submit claims*** for payment to Medicare on either a participating,[12] non-participating[13] basis, or while remaining enrolled, have formally opted out.

Ambiguity arises because Medicare laws uses variants of "participate" in two very different ways:

1. Sec. 1866. [42 U.S.C. 1395cc] (a)(1) [14] defines a physician as "qualified to ***participate***" in Medicare and "eligible for payments" if he or she voluntarily chooses to file "with the Secretary an agreement…" This is the fundamental "Enrollment Process."

   Sec. 1848. [42 U.S.C. 1395w–4] (g)(4)(A)[15] "Physician Submission of Claims" can only apply to an ***enrolled*** physician ("qualified to ***participate***" under Sec. 1866. [42 U.S.C.

---

[12] Sec. 1842. [42 U.S.C. 1395u] (b)(6)(A) "The term "***participating physician***" refers … to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)); the term "nonparticipating physician" refers, with respect to the furnishing of services, to a physician who … is not a participating physician … (as defined in subsection (h)(1))." "(h)(1) Any physician … may ***voluntarily*** enter into an agreement with the Secretary to become a participating physician …. For purposes of this section, the term "participating physician or supplier" means a physician … who … enters into an agreement with the Secretary which provides that such physician … ***will accept payment*** under this part on an assignment-related basis ***for all items and services*** furnished to individuals enrolled under this part during such year." (Emphasis added)

[13] Sec. 1848. [42 U.S.C. 1395w–4] (g)(1)(A) "Limitation of actual charge.—In the case of a ***nonparticipating physician*** … or other person (as defined in section 1842(i)(2)) who ***does not accept payment on an assignment-related basis*** for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply: (i) Application of limiting charge.—No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service. (ii) No liability for excess charges.—No person is liable for payment of any amounts billed for the service in excess of such limiting charge." (Emphasis added)

[14] Sec. 1866. [42 U.S.C. 1395cc] (a)(1) AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES "(1) Any *provider* of services (except a fund designated for purposes of section 1395f (g) and section 1395n (e) of this title) shall ***be qualified to participate*** under this subchapter (Medicare) and shall ***be eligible for payments*** under this subchapter ***if*** *it files with the Secretary an agreement…*" (Emphasis added)

1395cc] (a)(1)) who is eligible to "***submit a claim*** for such service on a standard claim form specified by the Secretary ***to the carrier*** on behalf of a beneficiary…"

2. Sec. 1842. [42 U.S.C. 1395u] (h)(1) defines a ***"participating"*** physician as one who agrees to accept payment from Medicare on an assignment-related basis for all items and services. Although Sec. 1842 is silent on the prerequisite enrollment requirement, Sec. 1866 makes it clear that ***only*** a physician who chooses to file "with the Secretary an agreement…" is "qualified to participate" in Medicare and is "eligible for payments" from Medicare.

   Although still silent on the prerequisite enrollment requirement, Sec. 1842 further defines a ***"non-participating"*** physician as one who does not agree to accept payment on an assignment-related basis for all claims paid by Medicare. Sec. 1842's specific definition of "non-participating" is confusing, and some may apply it erroneously to describe a physician who does not enroll in Medicare and thus is not obligated to Medicare at all. Sec. 1848(g)(1)(A) "Limitation of Actual Charges" can also only apply to an ***enrolled*** physician **"**qualified to ***participate***" under Sec. 1866. [42 U.S.C. 1395cc] (a)(1) who must "***submit a claim to the carrier"*** but is ***"non-participating"*** under Sec. 1842. [42 U.S.C. 1395u] (h)(1).

Before the issue of "participating" or "non-participating" is reached a physician must have already voluntarily ***enrolled***.

Medicare acknowledges that "mandatory claim submission provisions of Sec. 1848(g)(4) apply to a physician who "must submit a claim to Medicare" and "must be enrolled in the Medicare program"[16] but may sometimes overlook the choice that physicians have to either enroll or not enroll in the program.

---

[15] Sec. 1848. [42 U.S.C. 1395w–4] (g)(4)(A) "Physician submission of claims.—In general.—For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a ***physician***, supplier, or other person (or an employer or facility in the cases described in section 1842(b)(6)(A))—(i) ***shall complete and submit a claim*** for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and (ii) may not impose any charge relating to completing and submitting such a form." (Emphasis added)

[16] See https://questions.cms.hhs.gov/app/answers/detail/a_id/9931/~/what-are-the-mandatory-claim-submission-rules%3F "When a physician … furnishes a service that is covered by Medicare, then it is subject to the ***mandatory claim submission provisions of section 1848(g)(4)*** of the Social Security Act (the Act). Therefore, if a physician … charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the ***physician or supplier must submit a claim to Medicare***. In order to receive payment for Medicare covered items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider … ***must be enrolled in the Medicare program***." (Emphasis added. Note: this is Medicare's response to a question, not a quote from the law. It confuses un-enrolled status with enrolled.)

DRAFT

PROPOSAL: A PHYSICIAN MAY CHOOSE NOT TO ENROLL IN MEDICARE

17. Where can physicians and their patients find complete information explaining reimbursement for services provided or ordered by a physician who chooses not to enroll in Medicare?

Since Medicare does not qualify, privilege, or regulate a physician who chooses not to enroll in Medicare, there are limited federal policies pertaining to such physicians.

Medicare beneficiaries may find some assistance in the Medicare Beneficiary Manual: http://www.cms.gov/manuals/downloads/clm104c01.pdf (quoted in Footnote 6, above).

SUMMARY

Most physicians enroll in the Medicare program Part B and are thereby eligible to submit bills to Medicare. Reasons for physician enrollment may vary and include contractual obligations with other entities such as Medicare Advantage and some hospital medical staffs.

There is no law that requires every physician to serve Medicare. Physicians who choose not to enroll in the Medicare program Part B may bill their patients who are Medicare beneficiaries; these patients may seek reimbursement from Medicare.

This proposal demonstrates that Medicare can function now the same way that medical insurance used to work when patients paid for their own medical care and recovered some of their expenses from insurance policies intended to limit risk and protect from catastrophe.

DRAFT

PROPOSAL: A PHYSICIAN MAY CHOOSE NOT TO ENROLL IN MEDICARE

309122418

CMS Medicare Summary Notice

Page 1 of 3

CUSTOMER SERVICE INFORMATION

Your Medicare Number: [redacted]

If you have questions, call 1-800 MEDICARE (1-800-633-4227) (#01102)

Ask for Doctor's Services
TTY for Hearing Impaired: 1-877-486-2048

BE INFORMED: You may see some claims that have been adjusted. For an explanation see the General Information section.

This is a summary of claims processed on [redacted]/2011.

PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim number [redacted]						
Bene Submit Placeholder, PO Box 182933, Columbus, OH 43218-2933						c,d,e
[redacted]/11	1.0 Psytx off 45-50 min w/e&m (90807)	$150.00	$114.99	$63.25	$0.00	a,b
[redacted]/11	1.0 Psytx off 45-50 min w/e&m (90807)	150.00	114.99	63.25	0.00	a,b
	Claim Total	$300.00	$229.98	$126.55	$0.00	

Notes Section:

a Outpatient mental health services are paid at 55% of the approved amount.

b Your doctor did not accept assignment for this service. Under federal law, your doctor cannot charge more than $ 132.24. If you have already paid more than this amount, you are entitled to a refund from the provider.

(continued)

EOF 3546(06/08)

THIS IS NOT A BILL - Keep this notice for your records.

MC4235-070207

P.O. Box 30755
Salt Lake City UT 84130-0755
Phone: 877-862-1158

PAGE: 1 OF 3
DATE:
ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN:

CHECK NUMBER:
CHECK AMOUNT: $310.44

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE RECEIVED	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	BENEFIT AVAILABLE	RMK CD
EE									
	Other Service	07/21/2011	9/2011	150.00	-28.24	114.99	.00	51.74	FO3
	Other Service	07/21/2011	3/2011	150.00	-28.24	114.99	.00	51.74	FO3
	Other Service	07/21/2011	/03/2011	150.00	-28.24	114.99	.00	51.74	FO3
	Other Service	07/21/2011	/12/2011	150.00	-28.24	114.99	.00	51.74	FO3
	Other Service	07/21/2011	/18/2011	150.00	-28.24	114.99	.00	51.74	FO3
	Other Service	07/21/2011	/26/2011	150.00	-28.24	114.99	.00	51.74	FO3

** PATIENT PAYS .00

** DEFINITION: "PATIENT PAYS" IS THE AMOUNT, IF ANY, OWED YOUR PROVIDER. THIS MAY INCLUDE AMOUNTS ALREADY PAI TO YOUR PROVIDER AT TIME OF SERVICE.

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
FO3 - We have processed these charges in coordination with Medicare's payment.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$310.44

etach Check

UBHF-EOB
Detach Check

ii