Doctor Name, M.D.

Address
City, St Zip
Phone 999-999-9999
Fax 999-999-9999

I, Doctor Name, M.D., declare under penalty of perjury that the following is true and correct to the best of my knowledge, information, and belief:

1. I am a physician licensed to practice medicine in the state of State. My identifying information is as follows:

Name:	Doctor Name, M.D.
Address:	Address
	City, St Zip
Telephone:	999-999-9999
UPIN:	xxx
Provider ID:	xxx
Tax ID:	99-9999999

2. I promise that, for a period of at least two years beginning on the date that this affidavit is signed, I will be bound by the terms of both this affidavit and the private contracts that I enter into pursuant to this affidavit.

3. I herby confirm that, except for emergency or urgent care services (as specified in 3044.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 3044.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.

4. I hereby confirm that 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 3044.28.

5. I hereby confirm that, 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+Choice plan.

6. I hereby acknowledge that as a physician who opts out of Medicare, 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.

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

8. I hereby acknowledge that I recognize 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 beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

9. I hereby acknowledge that I 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 3044.28 apply if I furnish such services.

10. A copy of this affidavit is being filed with "insert name and address of your local Medicare Carrier", the designated agent of the Secretary of the Department of Health and Human Services, no later than 10 days after the first contract to which this affidavit applies is entered into.

Executed on Date by Doctor Name, M.D.

____

Doctor Name, M.D.