Harvard Pilgrim Health Care

a Point32Health company

Medicare Opt-Out Form

All requested information **must be filled out** for form to be valid

This is to certify that _____ ("Provider")

Provider's printed name

has opted out of Medicare beginning _____.

MM/DD/YYYY

Provider confirms they do not submit claims to Medicare for any service furnished to a Medicare beneficiary while they have opted out of Medicare, nor does the Provider receive any direct or indirect Medicare payment for services that they provide to Medicare beneficiaries.

Provider acknowledges that while they have opted out of Medicare, their services are not covered under Medicare and that no Medicare payment will be made to any entity for its services, directly or on a capitated basis.

Provider confirms they have executed and filed the Medicare Opt-Out Form with all applicable Medicare Administrative Contractors.

Submission of this form does not guarantee reimbursement. Services are paid based on the coverage of the member's specific plan.

National Provider Identifier (NPI): _____

Signature of Provider: _____

Date Form signed:* _____

IMPORTANT: *Providers who have opted out of Medicare are required to submit this form with each Harvard Pilgrim Health Care claim for members of Commercial, Medicare Enhance or Medicare Supplement products and have Medicare as their primary insurer. Additionally, the form must be signed and be dated within the past two years.*