

Private Contract - Provider Opt-Out of Medicare

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Charleston, SC 29407

Beneficiary Name: _____

Legal Representative (if applicable): _____

Beneficiary Medicare Number: _____

This private contract is between the physician and the beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician above has informed the beneficiary or his/her legal representative that he has opted-out of the Medicare Program. The current Medicare opt-out period is from **May 28, 2017 to May 28, 2019**. At the end of this opt-out period, the physician's opt-out status will be automatically renewed for an additional two year period. You will be asked to complete an updated contract at that time if I wish to remain under the the care of this physician. The physician noted above is not excluded from participating in Medicare Part B under sections 1128, 1156, or 1892 of the Medicare Act.

The beneficiary or his/her legal representative has read and agrees to the following terms of the private contract by placing his/her INITIALS in the box beside each statement below:

- I, or my legal representative, accept full responsibility for payment of the physician or practitioner's charge for all services furnished by this physician.
- I, or my legal representative, understand that Medicare limits do not apply to what the physician may charge for items or services that he furnishes.
- I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare. If I have a supplemental policy that will reimburse me for a portion of what I have paid to the physician only after I have received an official claim denial from Medicare, I understand that the physician will provide me with a document explaining this and that this document is to be submitted by me to Medicare along with each statement showing that I have paid the physician in full and am requesting a denial from Medicare rather than a paid claim.
- I, or my legal representative, have been informed of the expiration date of the current opt-out period, which is **May 28, 2017 to May 28, 2019**, and I understand that I will be asked to complete an updated contract at that time if I choose to remain under the care of this physician.

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- I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I, or my legal representative, enter into this contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and/or practitioners that have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have opted out of Medicare.
- I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. I understand that some supplemental plans may elect to make payments after first being furnished with proof of official claim denial from Medicare, and that the physician will provide me with a document to facilitate the process of obtaining such proof if I have this type of supplemental plan.
- I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Beneficiary or Legal Representative's Signature

Date

Physician's Signature

Date

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