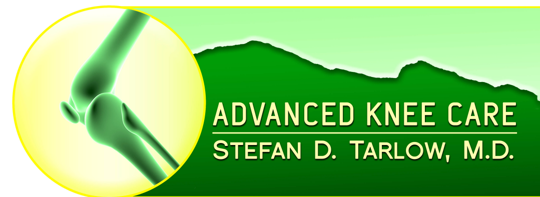

ADVANCED KNEE CARE P.C.

STEFAN D. TARLOW, M.D.

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Suite 105
Scottsdale, AZ 85258

T (480) 483-0393
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tarlowknee@gmail.com

Medicare Private Contract

Name of Medicare Beneficiary:_______________________________________

Medicare ID#: ____

Medicare Beneficiary Address:_______________________________________

____

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a **Medicare beneficiary**. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out.

I **Stefan D. Tarlow, M.D.** have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act:1962509448 (provider's NPI).

I **the Medicare beneficiary** or my legal representative accept full responsibility for payment of charges for all services furnished by **Stefan D. Tarlow, M.D.**.

I **the Medicare beneficiary** or my legal representative understand that Medicare limits do not apply to what **Stefan D. Tarlow, M.D.** may charge for items or services furnished.

I **the Medicare beneficiary** or my legal representative agree not to submit a claim to Medicare or to ask **Stefan D. Tarlow, M.D.** to submit a claim to Medicare.

I **the Medicare beneficiary** or my legal representative understand that Medicare payment will not be made for any items or services furnished by **Stefan D. Tarlow, M.D.** that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I **the Medicare beneficiary** or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
The effective date and the expiration date of the opt-out period is.
01/01/2021(effective date) and 12/31/2023(expiration date).

I **the Medicare beneficiary** 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.

This contract cannot be entered into by me, **the Medicare beneficiary**, or by my legal representative during a time when I, **the Medicare beneficiary**, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual)

I **the Medicare beneficiary** or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

I **Stefan D. Tarlow, M.D.** will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

I **Stefan D. Tarlow, M.D.** will supply CMS with a copy of this contract upon request.

I **Stefan D. Tarlow, M.D.** understand that the current private contract remains in effect for two years. When I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Medicare Beneficiary Signature:

____Date:_______________

Witness: ____Date: _______________

Provider Signature: _____________________________________Date:_______________