

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Physician or Supplier
Identification Code(s)*

Name(s) and Address of Participant*

Name _____

Address _____

City _____

State _____

Zip _____

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment** - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date** - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective
3. **Term and Termination of Agreement** - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
 - a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
 - b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of Participant
(Or authorized representative
of participating organization)

Title
(If signer is authorized
representative of organization)

Date

Received By _____
(Name of carrier)

Office Phone Number
(Including area code)

Effective Date _____

Initials of Carrier Official _____

*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington D.C. 20503.