

Private Contract – Provider Opt-Out of Medicare

Provider Name: Christian Wessling, M.D.

Provider Address: 7979 Big Bend Boulevard, Webster Groves, MO 63119

Beneficiary Name _____

Legal Representative (if applicable) _____

This private contract agreement is between the physician and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician named 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 December 9, 2024 to December 8, 2026. The physician noted above is not excluded from participating in Medicare Part B under §§1128, 1156 or 1892 of the Act.

As the beneficiary or his/her legal representative, I have read the private contract and agree to its terms as follows:

- I accept full responsibility for payment of the physician's or practitioner's charge for all services furnished by this physician/practitioner.
- I understand that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.
- I agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare.
- I have been informed of the expected or known expiration date of the opt-out period, which is December 9, 2024 to December 8, 2026.
- I understand that a Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- I enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare covered items and services from physicians and practitioners who 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 not opted out.
- I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid by Medicare.
- I 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 _____