VINTAGE DIRECT PRIMARY CARE
MODERN CARE. OLD TIME SERVICE

Medicare Waiver

Medicare Beneficiary Addendum

This Medicare Beneficiary Addendum is entered into by _____ ("Member") and Vintage Direct Primary Care, PLLC, through its physician, Dr. Peter Lehmann, as provided for in section 4507 of the Balanced Budget Act of 1997.

The Member has become a member of Vintage Direct Primary Care to receive primary care services from Dr. Peter Lehmann, who has opted out of the Medicare program, effective January 1, 2016, for a period of at least two years for all covered goods and services he furnishes to Medicare beneficiaries. Dr. Lehmann has not been excluded from participation in Medicare Part B under section 1128, 1156, or 1892 of the Social Security Act.

The Member agrees to give up Medicare payment for goods and services furnished by Vintage Direct Primary Care and to pay Vintage Direct Primary Care the monthly enrollment fee and other fees charged for services or supplies not included in the membership without regard to any limits that would otherwise apply to what Vintage Direct Primary Care could charge if receiving payment from Medicare.

Specifically, by signing this Medicare Beneficiary Addendum the Member affirms the following:

1. I acknowledge that payment for goods or services provided under my Vintage Direct Primary Care membership is my responsibility and not the responsibility of Medicare.
2. I agree not to submit a claim or to request Vintage Direct Primary Care to submit a claim for payment under Medicare, even if Medicare would otherwise cover such goods and services.
3. I further acknowledge that payment limits under Medicare do not apply to goods or services provided under the Vintage Direct Primary Care membership.
4. I also understand that Medigap plans do not –and other supplemental insurance plans may not—pay for good or services provided under the Vintage Direct Primary Care membership.
5. Finally, I understand that as a Medicare beneficiary, I have the right to receive medical services provided by other physicians for whom payment would be made by Medicare.

Member Signature: _____ Date: _____

Physician Signature: _____ Date: _____