AGREEMENT TO RECEIVE
MEDICARE VALUE BASED CARE MANAGEMENT

Medicare covers various value based services including chronic care management services, behavioral health integration, and remote patient monitoring provided by your doctor per calendar month. I understand that my primary care physician _____ is willing to provide such services to me, including the following:

• Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other face-to-face and non-face-to-face means of communication.
• The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
• Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management, As well as monitoring measurements of my health data and follow up psychiatric health questionnaires
• A comprehensive plan of care for all my health issues that is specific to me,
• Management of my care as I move between and among health care providers and settings, including the following:
Referrals to other health care providers,
Follow-up after I visit an emergency department,
Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
• Coordination with home- and community-based providers of clinical services.

I understand that I will receive a copy of my comprehensive plan of care.
I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or healthcare professional to furnish services within a given calendar month.
I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.
I hereby indicate by signature on this agreement that Dr._____ is designated as my primary care physician for purposes of providing Medicare value based care services to me.
My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in value based care services.
This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____
Patient or guardian signature: _____
Date: _____