Medicare Advanced Primary Care Services

At Andover Family Medicine, your health is our priority and it's our privilege to care for you. We already provide ongoing care that goes far beyond office visits – helping you stay healthy, supported, and connected.

Medicare has a new program called **Advanced Primary Care Management (APCM)**. This program simply allows Medicare to recognize and support the care you already receive from your primary care provider.

In agreeing to receive APCM services, I understand that my provider and the Andover Family Medicine care team are willing to provide such services to me, including the following:

Access and continuity of care

- 24/7 access to the care team (appointments, phone calls, or patient portal)
- Ability to get routine appointments with a member of the care team
- Alternatives to traditional office visits (such as telehealth or Saturday hours)

Comprehensive Care Management

- A care plan tailored to your health goals that is updated regularly
- Help staying on track with important screenings and preventive care
- Support managing medications safely and effectively
- Needs assessment, including medical and psychosocial
- A copy of your care plan accessible to you, your caregivers, and care team

Care Coordination

- Coordinate your care with specialists, hospitals, and community services
- Manage referrals, review records, and keep all providers on the same page
- Follow-up after hospital stays or ER visits to keep your recovery on track

I understand that I can stop this program at any time, and the change will take effect at the end of the calendar month. If I choose to stop, I can choose to receive these services from another health care provider beginning the following month. Medicare only allows one provider or clinic to provide this service in any given month. I also understand that APCM services are subject to the usual Medicare deductible and coinsurance. Depending on my individual coverage, I may have a monthly fee. By signing this form, I give my doctor permission to share my medical information with other providers when needed to coordinate my care. This agreement is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): ____

Signature: ________________________________ Date: ____________________