COVID-19 ACCELERATED AND ADVANCE PAYMENT REQUEST

The Centers for Medicare & Medicaid Services (CMS) has expanded the Accelerated and Advance Payment Program to provide financial relief to Medicare providers/suppliers working to provide treatment to patients and combat the 2019-Noval Coronavirus (COVID-19) pandemic. The expansion of this program is only for the duration of the public health emergency.

Instructions:

- Please type your responses on the request. The completed request must be printed and signed by the provider's/supplier's authorized official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf. Digital signature is an allowed form of authorization.
- Complete all fields to prevent delays in processing.
- If you need to request a payment for more than one Medicare Identification Number (PTAN), include a separate list of each Medicare Identification Number (PTAN) and matching National Provider Identifier (NPI) with this request. This will ensure faster processing of your request. The authorized official **must** have authority to sign on behalf of all parties.
- To identify your applicable MAC and for further guidance, reference the following link: http://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
- Your MAC will notify you of the decision and when you'll receive payment to the email listed on the form.

Contract/Workload ☐ Jurisdiction 15 Part A KY ☐ Jurisdiction 15 Part A OH ☐ Jurisdiction 15 Home Health & Hospice

COMPLETE ALL FIELDS BELOW

Provider Name

Phone Number

Medicare Identification Number (PTAN) or
☐ list attached

Fax Number

NPI Number or
☐ list attached

Email Address

I certify that the provider has no plans to:

☐ file for bankruptcy, is currently in bankruptcy, nor has retained bankruptcy counsel.

☐ cease doing business.

☐ I certify that the provider/supplier is not under fraud investigation.

Check the reason for your request:

☐ Delay in provider/supplier billing process is of an isolated temporary nature beyond the provider/supplier's normal billing cycle due to COVID-19 and not attributable to other third party payers or private patients.

Payment Amount Requested (select **ONE** option below)**:**

☐ I want the maximum payment amount as calculated by CMS.

☐ I want less than the maximum payment amount as calculated by CMS.
Enter payment amount requested: $

I _____ (Name), _____ (Title),
certify that I'm the authorized official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.

Signature of authorized official listed above.

Date

The request may be submitted to CGS via:

Email: CGS.ERS.CORR@cgsadmin.com

Fax: 1.615.664.5949

Mail to: CGS Administrators, LLC
ATTN: CFO Accelerated Payments
PO Box 20018
Nashville, TN 37202

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