EXTENDED REPAYMENT SCHEDULE UNDERPAYMENT/REFUND ELECTION

PROVIDER NAME:	
PROVIDER NUMBER:	
UNDERPAYMENT/REFUND AMOUNT:	
UNDERPAYMENT/REFUND NOTIFICATION LETTER DATE:	
ERS LOAN/RECEIVABLE NUMBER:	

Indicate selection and return no later than 15 calendar days from the date of the notification letter.

Apply underpayment to ERS overpayment balance

Rescind any previous elections and refund underpayment balance (Justification for refund request must be provided below. Please provide current financials and other relevant information to support justification (example: income statement, balance sheet, cash flow statement) and include certification statement: https://www.cgsmedicare.com/ers/certification_statement.html).

Justification (attach additional page(s) if necessary):

If the person signing below is not also the Provider, the signer certifies that he has obtained authorization from the provider to execute this document on behalf of the Provider.

OFFICER/OWNER/ ADMINISTRATOR SIGNATURE:	
PRINTED NAME:	
TITLE:	
DATE:	

Election form may be returned via fax to 1.615.664.5949 or mailed to the address shown below.

To receive a paper copy of the form, please contact CGS at CGS.ERS.CORR@cgsadmin.com.

CGS Administrators, LLC
ATTN: CFO Reporting
PO Box 20018
Nashville TN 37202

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