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 ☐ Jurisdiction 15 Part B KY ☐ Jurisdiction 15 Part B OH ☐ DME Jurisdiction B ☐ DME Jurisdiction C

COMPLETE ALL FIELDS BELOW

Provider Name	Phone Number
Medicare Identification Number (PTAN) or ☐ list attached	Fax Number
NPI Number or ☐ list attached	Email Address

Check the reason for your request (select **ONE** option below):

- ◯ 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.
- ◯ Other: *Please explain...*

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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