National Government Services

A CMS Medicare Administrative Contractor

MEDICARE

# Request for Accelerated/Advance Payment

## Provider and Point of Contact Information:

Provider Name: _____ Contact Name: _____

Medicare Identification Number (PTAN) or attached list: _____ Contact Phone Number: _____

Contact Email Address: _____

National Provider Identification (NPI) Number or attached list: _____

**Jurisdiction and Provider Type (Select one):**

J6 Part A ☐ J6 Part B ☐ JK Part A ☐ JK Part B ☐

## Select 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 (if additional explanation is needed, include attachment on company's letterhead)

_____

_____

## 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 $ _____

## Authorized Representative Certification:

I attest that I am the authorized official that is legally able to make financial commitments and assume financial obligation on the provider's/supplier's behalf.

**Signed:** _____ **Date:** _____

**Print Name:** _____ **Title:** _____

Completed forms and attachments should be sent to the email address that corresponds with the jurisdiction and provider type:

**J6 Part A:** J6AcceleratedPaymentPartA@anthem.com **JK Part A:** JKAcceleratedPaymentPartA@anthem.com

**J6 Part B:** J6AdvancePaymentPartB@anthem.com **JK Part B:** JKAdvancePaymentPartB@anthem.com



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