National Government Services

A CMS Medicare Administrative Contractor

MEDICARE

Request for Accelerated/Advance Payment

Provider Name _____ **Provider Number** _____

Provider Address _____ **National Provider Identification Number (NPI)** _____

Jurisdiction (Check One):

Jurisdiction 6 ◯ **Jurisdiction K** ◯

Provider Type (Check One):

Part A ◯ **Part B** ◯

Requested Amount **$** _____

Point of Contact Information

Name _____

Phone Number _____

Email Address _____

Note: Medicare Administrative Contractors (MACs) will take the requested amount into consideration with other financial factors on record and Centers for Medicare & Medicaid Services (CMS) directives. MACS may determine based on those records, that only a partial payment is appropriate.

Please state the reason for your request: _____

All request forms for accelerated/advance payments should be sent to one the following email addresses based on jurisdiction:

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

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

Include a written request on your company letterhead. Request for accelerated/advanced payments will only be approved and processed if all of the following apply:

1. The provider has billed claims during the 180 days prior to the request
2. The provider does not have any outstanding/accelerated advanced payments pending for more than 90 days
3. The provider is not in default or delinquent with any pending overpayments
4. The provider is not under fraud investigation
5. The provider has not filed for bankruptcy
6. The providers impaired cash position must be such that it would not be alleviated by receipts anticipated within 30 days of the request.

In addition to the National Government Services Accelerated/Advance payment form, providers are required to also submit, on their organizations letterhead, a detailed explanation of the system issue they are experiencing; specifically, whether the issue is CMS related or due to the provider's internal systems issues.

Attestation By Authorized Representative

I attest that I have reviewed the aforementioned criteria and the organization I represent is in compliance with these criteria.

Signed _____ **Date** _____

Print Name _____

Title _____

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES