noridian
Healthcare Solutions

Form Approved
OMB NO. 0938-0269

Provider Request for Accelerated Payment

1. Provider Name: _____ Provider No: _____

   Address: _____

2. Intermediary: _____

3. Check (a) or (b) or both if applicable:

   Check Box ☐ (a) Abnormal delays in Title XVIII claims processing and/or payment by the health insurance intermediary.

   Check Box ☐ (b) Delay in provider billing process of an isolated temporary nature beyond the provider's normal billing cycle and not attributable to other third-party payers or private patients.

4. a. General cash fund position for provider as of _____ _____

   b. Anticipated receipts from all sources (exclusive of accelerated payments) in the next 30 days _____

   c. Anticipated expenditures in next 30 days _____

   d. Indicated cash position in next 30 days (a + b – c) _____

PRM Section 2412.2

Print Form