Accelerated Payment Request Certification – COVID-19

I, _____, _____ certify the
(Name) (Title)

validity of the request for an accelerated payment by _____
(Provider Name)

in the amount of $_____ from the Medicare Program.

Provider Number (PTAN): _____ Email address: _____

Specifically, I certify the accuracy of the statements checked below:

☐ I understand that Medicare is making an advanced payment for services already provided.

☐ The provider has put forth a good faith estimate of the amount actually due for services already provided.

☐ The accelerated payment will be used to operate the provider, and will not be used for payments outside the provider's ordinary course of business.

☐ The provider has no plans to file bankruptcy.

☐ The provider has no plans to cease doing business.

Check reason for request:

☐ Delay in provider billing process of an isolated, temporary nature beyond the provider's normal billing cycle due to COVID 19 and not attributable to other third-party payers or private patients

☐ Other (please explain): _____

_____

Pursuant to 28 U.S.C. Section 1746, I declare under penalty of perjury that I have investigated the matters that are subject of this document, and that the information provided is true and correct.

Signed: _____ Dated: This __ day of _____, _____
(Name and Title)

Email completed form to AccAdvPymtReq@wpsic.com