PALMETTO GBA
A CELERIAN GROUP COMPANY

PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION
FIELDS WITH A RED ASTERISK (*) ARE REQUIRED.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

Provider Information

Provider Name*

National Provider Identifier (NPI)*

Provider Number (PTAN)*

Contact Information

Phone Number* ( ) -

Fax Number ( ) -

Email Address*

Authorized Official

Name*

Title*

Please select the reason for your request *

- ○ 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 below)

Payment Amount Requested *

- ○ I want the maximum payment amount as calculated by CMS.
- ○ I want less than the maximum payment amount as calculated by CMS. Amount Requested:

Signature

- ☐ I certify that the provider has no plans to file for bankruptcy, is currently in bankruptcy, nor has retained bankruptcy council.
- ☐ I certify that the provider has no plans to cease doing business.
- ☐ I certify that the provider/supplier is not under fraud investigation.
- ☐ I certify that I am 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* / /

Please send this form and all additional documentation to:

Mail

Palmetto GBA, LLC
Advance Payments (AG-330)
2300 Springdale Drive, Bldg One
Camden, SC 29020

Email

JM.FINANCIALRELIEF@palmettogba.com