



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



### Request for Accelerated / Advance Payment

**ALL fields are REQUIRED.**

#### Provider Information

#### Contact Information

Provider Name:

Contact Name (Please Print):

Provider Address:

  

Contact Phone Number:

(  )  -

National Provider Identifier (NPI):

Contact E-mail Address:

Provider Number (PTAN):

Cash balance is seriously impaired due to (please check all that apply):

- Abnormal delay in title Medicare claims processing and/or payment by the MAC.
- 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. **(Explanation Required)**

Explanation:

  
  

A. General fund cash position for provider:

As of date:

/  /

B. Anticipated receipts from all sources in next 30 days (Exclude accelerated payments):

C. Anticipated expenditures in next 30 days:

D. Indicated cash position in next 30 days (A + B - C):

E. Total Accelerated/Advance Payment Amount Requested:

Period of Time Covered (# of months):

Signature:

Date:

I certify that I am an authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's behalf.

Please send this form and all additional documentation to:

FN-JJ-B-2005



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