Jurisdiction H - Medicare Part A and B

Accelerated and Advance Payment Request Form

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 form. The completed form must include the **electronic or handwritten signature** of the provider's/supplier's authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf. If not signed by the authorized representative, the request will be denied.
- The request form must include the Medicare Identification Number (or PTAN) and National Provider Identifier (NPI) that receives payment. If an individual PTAN and NPI are reassigned to a billing group, the PTAN and NPI for the billing group must be submitted.
- If you need to request a payment for more than one PTAN, submit a separate form for each PTAN and matching NPI. Do not password protect the form.
- Novitas Solutions will notify you of the decision and when you'll receive payment to the email listed on the form.
- Providers will have to pay back the accelerated/advance payment.

Request forms must be uploaded through our Provider Enrollment Gateway at:
https://www.novitas-solutions.com/webcenter/portal/Enrollment_JH/EnrollmentGateway

Our Gateway entry page includes a help guide on accessing the tool and submitting your request form.
Only PDF formats are accepted on the Gateway.

Provider Name:	Phone Number:
Medicare Identification Number (PTAN):	Fax Number:
NPI:	Email Address:

Select one option below	Check 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

Select one option 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. Enter payment amount requested _____________.

I ____________________ (Name), ____________________ (Title), certify that I'm the authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.

Signature of authorized representative listed above:	Date: