Accelerated Payment Calculation

Provider Number:
Preparer Name:
Preparer Title:
Preparer Telephone:

A. Inpatient (Hospital and Skilled Nursing Facility)

Unbilled
Number of discharges unbilled
Number of patient days represented
Amount of Charges

Billed
Number of bills not paid
Number of patient days represented
Amount of Charges
Total
Interim reimbursement rate
Interim amount due
Less: deductible and coinsurance
Net reimbursement
Maximum percentage
Inpatient accelerated payment requested (A) 70%

B. Outpatient or Home Health

Unbilled
Amount of charges
Number of visits or occasions of service

Billed
Amount of charges
Number of visits or occasions of service
Total
Interim reimbursement rate
Interim amount due
Less: deductibles and coinsurance
Net Reimbursement
Authorized rate 70%
Outpatient accelerated payment requested (B) 0

C. Total Accelerated Payment requested: (A) and (B) $ -