noridian
Healthcare Solutions

Accelerated Payment Calculation

Provider Number:

Preparer Name:
Preparer Title:
Preparer Telephone:

A. Inpatient (Hospital and Skilled Nursing Facility)

		Per Diem Basis	Charge Basis
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		70%
	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	0
	Interim reimbursement rate	
	Interim amount due	0
	Less: deductibles and coinsurance	
	Net Reimbursement	0
	Authorized rate	70%
	Outpatient accelerated payment requested (B)	0

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