noridian
Healthcare Solutions

Accelerated Payment Request Certification

I, *(Name)*_____, (*Title must be CFO or higher)* _____

Certify the validity of the request for an accelerated payment *(Provider)* _____ by

_____ in the amount of $ _____from the Medicare program.

Specifically, I certify the accuracy of the statements checked below:

_____ I understand that Medicare is making an accelerated payment for services already provided.

_____The provider has put forth a good faith estimate of the amount actually due for services already provided.

_____The accelerated payment will be used to operate the Provider, and will not be used for payments outside of the Provider's ordinary course of business as an operating facility.

_____ The Provider has no plans to file for bankruptcy.

_____ The Provider has not retained bankruptcy counsel.

_____ The Provider has no plans to cease doing business.

In signing for the Provider, and myself, I understand that false statements are punishable as felony under 18 U.S.C. § 1001, which provides as follows:

> Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title, or imprisoned not more than five years, or both.

Signed: *(Name and title)*_____

Dated this _____ Day of _____, 20_____