

All the listed items must be submitted to the carrier in order to begin the process of determining financial hardship. If you are unable to furnish one or more of the required documents, please submit a statement explaining the reason for the delay or inability.

Payee Number: \_\_\_\_\_

Invoice Number: \_\_\_\_\_

Included  
 Not Included

Amortization Schedule – A written request must be submitted that refers to the specific overpayment for which an extended repayment is being requested. This request must detail the number of months requested, indicate the approximate monthly payment amount (principal and interest, if possible), and include the first payment along with any future payments due while the request is under review.

Included  
 Not Included

A copy of the overpayment notification letter.

Yes  
 No

Elect to have any underpayments or manual refunds automatically applied to their overpayment after approval of ERS request.

Note: If the ERS request is for 6 months, this is the only documentation required. Please sign, date and fill out the disclosure statement on the last page.

**The following documentation is also required for all ERS requests 7 months or greater:**

**If a sole proprietor:**

Included  
 Not Included

A completed Form CMS-379 (Financial Statement of Debtor). To obtain a form you may access the CMS Web site at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS008774.html>

Included  
 Not Included

Income Tax Return from the most recent calendar year.

Included  
 Not Included

Financial Statements

Included  
 Not Included

A request for an extended repayment of 36 months or more must also be accompanied with at least one letter from a financial institution denying the debtor's loan request for the amount of the overpayment.

## If not a sole proprietor:

- |  |  |
|--|--|
| <input type="checkbox"/> Included  | Balance Sheets - The most current balance sheet and the one for the last complete fiscal year (preferably prepared by your accountant). If consolidated statements (including more than one entity) are submitted, separate statements showing the individual provider's contribution must also be submitted.          |
| <input type="checkbox"/> Not Included  |  |
| Note: If the time period between the two balance sheets is less than six months (or you cannot submit balance sheets prepared by your accountant), you must submit balance sheets for the last TWO complete Medicare fiscal years in addition to the most current balance sheet. |  |
| <input type="checkbox"/> Included  | Income Statements related to the balance sheets (preferably prepared by your accountant).  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | Statement of Sources and Application of Funds - For the periods covered by the income statements.  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | Cash Flow Statements – For the periods covered by the balance sheets. If the date of the request for an extended repayment plan is more than three (3) months after the date of the most recent balance sheet, a cash flow statement should be prepared for all months between that date and the date of the request.  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | Projected Cash Flow Statement – Covering the remainder of the current fiscal year. If fewer than six (6) months remain, a projected cash flow statement for the following year should be included.   |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | List of restricted cash funds – by amounts as of the date of request and the purpose for which each fund is to be used. (if applicable)  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | List of investments – by type (stock, bond, etc.), amount, and current market value as of the date of the report. (if applicable)  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | List of notes and mortgages payable – by amounts as of the date of the report, and their due dates. (if applicable)  |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | Schedule showing amounts – due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations/persons, TIN and NPI numbers. It shall show where the amounts appear on the balance sheet, such as Accounts Receivable, Notes Receivable, etc. |
| <input type="checkbox"/> Not Included  |  |
| <input type="checkbox"/> Included  | Schedule showing types – amounts of expenses (included in the income statements) paid to related organizations. The schedule shall show names of the related organizations, TIN and NPI numbers.   |
| <input type="checkbox"/> Not Included  |  |

Included                      The percentage of occupancy – by type of patient (Medicare, Medicaid, private pay) and total available bed days for the periods the income statements cover.

Not Included

Included                      Loan Applications – Requests for extended repayment of 36 months or more. Have the debtor include at least one letter from a financial institution denying the debtor’s loan request for the amount of the overpayment.

Not Included

Note: If you are unable to furnish some of the documentation, you should fully explain why. All financial records must be for the business participating in the program. It should not be for the owner if the business is a partnership or a corporation. If an outside facility manages the financial aspects of the business, the provider shall submit individual financial records as well as the financial records of the outside facility.

Your first payment, referenced “ERS Request,” and made payable to Noridian Healthcare Solutions, LLC, along with the above requested information, should be mailed directly to:

Noridian Medicare JF PART B Refund  
PO Box 511359  
Los Angeles, CA 90051-7914

Please submit all documentation to which you have answered a “Not Included” response within 10 days of this request.

**Please ensure that all balance sheets and income statements include the following statements:**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER/ADMINISTRATOR OF PROVIDER(S)  
(For physicians/suppliers, “CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY THAT I HAVE EXAMINED THE BALANCE SHEET AND INCOME STATEMENT PREPARED BY \_\_\_\_\_ AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT FROM THE BOOKS AND RECORDS OF THE PROVIDER.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Officer or Owner of Debator(s): \_\_\_\_\_

Title: \_\_\_\_\_

