Noridian Accelerated and Advance Payment Request

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-Novel 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 request. The completed request must be printed and signed by the provider's/supplier's authorized official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.
- Digital signature is an allowed form of authorization.
- Complete all fields to prevent delays in processing.
- If you need to request a payment for more than one Medicare Identification Number (PTAN), include the list attached. This will ensure faster processing of your request. The authorized official must have authority to sign on behalf of all parties.
- For further guidance, see the CMS Fact Sheet at: http://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
- Your MAC will notify you of the decision and when you will receive payment to the email listed on the form.

Complete All Fields Below

Check one contract per form:

☐ **JE-Part A** or ☐ **JF-Part A** **Fax**: 701-277-6572 or **Email:** JE-reimb@noridian.com or JF-reimb@noridian.com

☐ **JE-Part B** or ☐ **JF-Part B** **Fax**: 701-277-7865 or **Email:** PartBadvancepayments@noridian.com

☐ **JA-DME** or ☐ **JD-DME** **Fax**: 701-277-7892 or **Email:** dmemsprecoupment@noridian.com

Provider Name: _____

Contact Phone Number: _____ Fax Number: _____

Email Address: _____

Medicare Identification Number (PTAN): _____ or ☐ List Attached

NPI Number: _____ or ☐ List Attached

I certify that the provider has no plans to:

☐ File for bankruptcy, is currently in bankruptcy, nor has retained bankruptcy counsel.

☐ Cease doing business.

☐ **I certify that the provider/supplier is not under fraud investigation.**

Check the Reason for Your Request

Select one option below:

☐ 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 _____

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Healthcare Solutions

Payment Amount Request

Select one option below:

☐ 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 official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.

Signature:_____ Date: _____

Noridian Accelerated/Advance Payment Provider Listing

Complete this form if you meet the following:

- If you need to request payment for **multiple** Medicare Identification Number (PTANs), and
- The authorized official has authority to **sign on behalf of all parties**.

Check either the maximum amount box or list the dollars requested. This is required for each PTAN/NPI combination.

Name of Provider	PTAN	NPI	Maximum Amount	Payment Requested
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