



Jurisdiction H - Medicare Part A Accelerated Payment Request Form

The Centers for Medicare & Medicaid Services (CMS) has expanded the Accelerated Payment Program to provide financial relief to Part A Medicare providers to provide treatment to patients and combat the 2019-Noval 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 form. The completed form must include the **electronic or handwritten signature** of the provider's authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's behalf. If not signed by the authorized representative, the request will be denied.
- The request form must include the Medicare Identification Number (or PTAN) and National Provider Identifier (NPI) that receives payment. If an individual PTAN and NPI are reassigned to a billing group, the PTAN and NPI for the billing group must be submitted.
- If you need to request a payment for more than one PTAN, submit a separate form for each PTAN and matching NPI. Do not password protect the form.
- Novitas Solutions will notify you of the decision and when you'll receive payment to the email listed on the form.
- Providers will have to pay back the accelerated/advance payment.

**Request forms must be uploaded through our Provider Enrollment Gateway at:
https://www.novitas-solutions.com/webcenter/portal/Enrollment_JH/EnrollmentGateway**

Our Gateway entry page includes a help guide on accessing the tool and submitting your request form.
Only PDF formats are accepted on the Gateway.

Provider Name:	Phone Number:
Medicare Identification Number (PTAN):	Fax Number:
NPI:	Email Address:

Select option/s below **I certify that the provider has no plans to:**

<input type="checkbox"/>	File for bankruptcy, is currently in bankruptcy, nor has retained bankruptcy counsel.
<input type="checkbox"/>	Cease doing business.

I certify:

<input type="checkbox"/>	The provider is not under fraud investigation.
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Select one option below **Check the reason for your request**

<input type="checkbox"/>	Delay in provider billing process is of an isolated temporary nature beyond the provider normal billing cycle due to COVID-19 and not attributable to other third party payers or private patients
<input type="checkbox"/>	Other: Please explain

Select one option below **Payment Amount Requested**

<input type="checkbox"/>	I want the maximum payment amount as calculated by CMS.
<input type="checkbox"/>	I want less than the maximum payment amount as calculated by CMS. Enter payment amount requested _____.

I _____, _____, certify that I'm the authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's behalf.

Signature of authorized representative listed above:	Date:
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