

**Request for Change Healthcare/Optum Payment Disruption (CHOPD)  
 Accelerated Payments to Part A Providers and Advance Payments to Part B  
 Suppliers**

Optum Insight/ Change Healthcare Cyber Incident (“the Incident”)

**Please note, providers receiving Periodic Interim Payments are not eligible to receive  
 CHOPD Accelerated Payments.**

Provider/Supplier Legal Business Name	Medicare Identification Number (PTAN)
National Provider Identification Number (NPI)	Tax Identification Number (TIN)
Authorized Official Name	Authorized Official Number
Authorized Official Email	Title of Authorized Official
Address	City
State	Zip
Contact Email	Contact Phone Number

For Authorized Representatives submitting multiple NPI/PTAN combinations

- Legal Business Name
- NPI
- PTAN
- TIN
- Amount requested or “Maximum” based on the options below.

**Authorized Official Certification**

By initialing and signing below, I attest that I am the authorized official that is legally able to make financial commitments and assume financial obligation on the provider’s/supplier’s behalf and certify that on best knowledge, information, and

belief that any required documentation furnished as part of this request, including the certifications and acknowledgements below, is accurate, complete, and truthful.

For Authorized Officials submitting multiple NPI/PTAN combinations: I attest that I am the authorized official that is legally able to make financial commitments and assume financial obligation on behalf of all NPI/PTANs that I am submitting. I certify that on my best knowledge, information, and belief that any required documentation furnished as part of this request, including the certifications and acknowledgements below, is accurate, complete, and truthful.

**Certification of Facts:**

\_\_\_\_\_ (Initials) I certify that the provider/supplier for which I am requesting an accelerated or advance payment has been unable to submit Medicare claims or receive Medicare claims payments due to the Incident affecting Change Healthcare and Optum on February 21, 2024.

\_\_\_\_\_ (Initials) I certify that the provider/supplier has experienced a disruption in Medicare claims payment or submissions due to a business relationship the provider/supplier has with Change Healthcare.

\_\_\_\_\_ (Initials) I certify that the provider/supplier has been unable to obtain sufficient funding from other available sources to cover the disruption in claims payment, processing, or submission attributable to the Incident.

\_\_\_\_\_ (Initials) I certify that the provider/supplier does not intend to cease business operations and presently is not insolvent.

\_\_\_\_\_ (Initials) I certify that if the provider/supplier currently is in bankruptcy, then it will send case information about the bankruptcy to CMS.

\_\_\_\_\_ (Initials) I certify that the provider/supplier is enrolled in the Medicare program and has not been revoked, deactivated, precluded, or excluded by CMS or OIG.

\_\_\_\_\_ (Initials) I certify that the provider/supplier does not owe the Medicare program any delinquent debts.

\_\_\_\_\_ (Initials) I certify that the provider/supplier does not currently have a payment hold or payment suspension associated with their Medicare provider/supplier billing agreement and/or billing number (PTAN/ CCN).

\_\_\_\_\_ (Initials) I certify that based on its best information, knowledge, and belief, the provider/supplier is not aware that the provider/supplier or a parent, subsidiary, or related entity of the provider/supplier is under an active healthcare-related program integrity investigation in which the provider/supplier or a parent, subsidiary, or related entity of the provider/supplier: (1) is under investigation for potential False Claims Act violations related to a federal healthcare program; (2) is a defendant in state or federal civil or criminal action (including a qui tam False Claims Act action either filed by the Department of Justice (DOJ) or in which DOJ has intervened); or (3) has been notified by a state or federal agency (including a state or federal prosecutor, the HHS Office of Inspector General, or the Centers for Medicare &

Medicaid Services (including its contractors, such as the Unified Program Integrity Contractors)), that it is a subject of a civil or criminal investigation or Medicare program integrity administrative action (e.g.: revocation of enrollment or payment suspension); or (4) has been notified that it is the subject of a program integrity investigation by a licensed health insurance issuer's special investigative unit (or similar entity).

\_\_\_\_\_ (Initials) I certify that the provider/supplier will use the funds received for operations of the specific provider/supplier for which the funds were requested.

**Acknowledgement of Terms of Accelerated/Advance Payments:**

\_\_\_\_\_ (Initials) I acknowledge that any accelerated/advance payment granted as a result of the Incident represents an advance on claims payments and is extended directly from the Medicare Trust Funds.

\_\_\_\_\_ (Initials) I acknowledge that accelerated/advance payments are not loans. They cannot be forgiven, and indebtedness cannot be reduced. There are no flexibilities available regarding the repayment timelines and CMS will use its standard recoupment procedures to recover these amounts.

\_\_\_\_\_ (Initials) I acknowledge that CMS will proceed directly to issuing a demand letter to recover any accelerated/advance payment in full if any information furnished in this request has been falsely attested, acknowledged, or certified.

\_\_\_\_\_ (Initials) I acknowledge that the availability of accelerated/advance payments as a result of this incident is not guaranteed, and payments will not be issued once the disruption to claims servicing related to the Incident is remediated, regardless of when the request is received.

\_\_\_\_\_ (Initials) I acknowledge that CMS maintains the right to conduct post payment audits related to any accelerated/advance payments issued under this program.

\_\_\_\_\_ (Initials) I acknowledge that the program length is dependent on the duration of the Incident, and its impact on the submission and/or processing of claims payments.

\_\_\_\_\_ (Initials) I acknowledge that CMS may terminate the program at any time.

\_\_\_\_\_ (Initials) I acknowledge that any funds issued under the accelerated/advance payment program for the Incident will be recouped at 100% offset of claims payments for a period of 90 days immediately following the date on which payments were issued to the requested entities.

\_\_\_\_\_ (Initials) I acknowledge that an overpayment demand letter will be issued for any remaining funds, which are not fully repaid within 90 days, on the 91<sup>st</sup> day following the issuance of the accelerated/advance payment.

\_\_\_\_\_ (Initials) I acknowledge that any debt demanded as a result of an outstanding balance of any accelerated/advance payment granted as a result of the Incident will accrue interest at the rate specified in 42 CFR 405.378.

\_\_\_\_\_ (Initials) I acknowledge that the provider/supplier understands that the acceptance of payments under the CHOPD program means that the provider/supplier expressly relinquishes any and all rights to appeal any resulting overpayment determinations issued for the recovery of these amounts, whether formally or informally and whether administratively or judicially.

**Payment Amount Requested**

I am requesting the maximum amount eligible, as calculated by CMS for accelerated/advance payments issued as a result of this Incident. This amount shall not exceed the average value of thirty (30) days of claims payments using the claims payment history for the 90 days preceding the date of the incident.

I am requesting less than the maximum payment amount as calculated by CMS (enter requested amount) \$\_\_\_\_\_

**Authorized Representative Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Official Title:** \_\_\_\_\_