national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Request for Accelerated/Advance Payment

Provider and Point of Contact Information:

Provider Name: _____ Contact Name: _____

Medicare Identification Number (PTAN) or attached list: _____ Contact Phone Number: _____

Contact Email Address: _____

National Provider Identification (NPI) Number or attached list: _____

Jurisdiction and Provider Type (Select one):

J6 Part A ☐ J6 Part B ☐ JK Part A ☐ JK Part B ☐

Explain the Reason for Your Request (if additional space is needed, include attachment on company's letterhead):

_____

_____

_____

Payment Amount Requested (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 $ _____

Authorized Representative Certification:

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.

I certify the following (select all that apply):

- The provider has no plans to file for bankruptcy, is not currently in bankruptcy and has not retained bankruptcy counsel.
- The provider has no plans to cease doing business.
- The provider/supplier is not under fraud investigation.

Signed: _____ **Date:** _____

Print Name: _____ **Title:** _____

Completed forms and attachments should be sent to the email address that corresponds with the jurisdiction and provider type:

J6 Part A: J6AcceleratedPaymentPartA@anthem.com **JK Part A:** JKAcceleratedPaymentPartA@anthem.com

J6 Part B: J6AdvancePaymentPartB@anthem.com **JK Part B:** JKAdvancePaymentPartB@anthem.com