national government SERVICES

A CMS Medicare Administrative Contractor
https://www.NGSMedicare.com

MEDICARE

Applying for an Extended Repayment Schedule

Any time a provider needs longer than 30 days to repay the full amount of an overpayment, the provider should submit a request for an extended repayment schedule (ERS). While a provider may request an ERS at any time during the debt-collection process, submittal within the first 40 days of the demand letter date may decrease the likelihood of a full withhold on interim payments.

To request an extended repayment schedule, please fax the required documents indicated on the list below along with the completed form and a copy of first month's good faith payment to:

- J6: jkextendedrepaymentschedules@anthem.com3

- If an incomplete ERS request is received, the contractor shall review the submitted documentation, determine and request all missing documents. If a good faith payment was not received, the MAC shall immediately place the provider on no less than 30% recoupment. If the contractor requests additional documentation and the information is not received by the 16th calendar day after the contractor's request, the contractor should close the request and resume normal collect activities.

If we do not hear from the provider regarding an ERS application within 40 days from the date of the demand letter, we will begin to recoup the overpayment by withholding interim payments at rate of 100 percent.

Any payments withheld will be applied to the outstanding overpayment and will not be refunded.

The maximum term allowed to request is sixty (60) months. Approved ERS will run from the date of the ERS approval date.

The provider must continue to submit monthly good faith payments until written approval or denial is received. If a provider fails to continue to submit monthly payments, we may initiate withhold of interim payments.

Any questions should be submitted to jkextendedrepaymentschedules@anthem.com. Additional information regarding the ERS process can be obtained by visiting our website.

Jurisdiction 6 providers should mail the first payment and the completed checklist directly to:

National Government Services
P.O. Box 809194
Chicago, IL 60680-9194

Your check should be made payable to **National Government Services** and reference "J6 B **ERS Request**."

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

ERS Request Form – Required Supporting Documentation

Please include all the documents below with your request. **Do not leave anything on this form blank.** Missing or incomplete documents can delay your application and increase the likelihood that interim payments may be withheld.

_____ Provider – NPI Number

_____ Invoice Number(s) (from the demand letter)

You must submit the following documentation if they are a **sole proprietor** to initiate the ERS request process:

- Items 1 and 2 – for ERS requests of six to fifteen months
- Items 1 through 8 – for ERS requests of sixteen to sixty months
- A valid Appointment of Representative (AOR) form is required for providers represented by third parties: CMS 1696

1) **Signed Proposed Amortization Schedule** – CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments.
2) **Good Faith Payments** – CMS requires the provider to submit the first good faith payment (per the proposed amortization schedule above), along with any future payments due while under review.
3) **CMS-379 Form** – CMS requires that all questions must be completed. Access the CMS website to obtain the CMS-379 Form Financial Statement of Debtor.
4) **Financial Statements** – CMS requires the provider to submit all the financial statements of the debtor.
5) **Income Tax Return** – The provider's income tax filing for the most recent calendar year.

The provider must submit the following documentation if they are **an entity other than a sole proprietor** to initiate the ERS request process:

- Items 1 and 2 – For ERS requests of six to fifteen months
- Items 1 through 12 – For ERS requests of sixteen to sixty months
- A valid Appointment of Representative (AOR) form is required for providers represented by third parties: CMS 1696

1.) **Signed Proposed Amortization Schedule** – CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment

2.) **Good Faith Payments –** CMS requires the provider to submit the first good faith payment (per the proposed amortization schedule above), along with any future payments due while under review.

3.) **Balance Sheets** – The provider's most current balance sheet and the balance sheet for the last complete Medicare cost reporting period or the most recent fiscal year.
   a. CMS **requires** that both the balance sheets and income statements include similar agreement language. (See Exhibit 1)
   b. **Note:** If the time period between the two balance sheets is less than six months or the

provider cannot submit balance sheets prepared by its accountant, it must submit balance sheets for the last two complete Medicare cost reporting periods (for providers that file a cost report) or for the last two complete fiscal years (for providers that don't file a cost report).

4.) **Income Statements** – Related to the balance sheets.
   a. CMS **requires** that both the balance sheets and income statements include similar agreement language. (See Exhibit 1)
5.) **Cash flow statements** – for the periods covered by the balance sheets. (see Exhibit 2) If the date of the provider's request for an extended repayment schedule is more than three months after the date of the most recent balance sheet, a cash flow statement shall be provided for all months between that date and the date of the request.
6.) **Projected cash flow statement** – from the date of the request and covering the remainder of the fiscal year. If fewer than six months remain, the provider shall include a projected cash flow statement for the following year. (see Exhibit 3)
7.) **List of restricted cash funds** – by amount as of the date of request and the purpose for which each fund is to be used, if applicable.
8.) **List of investments** – by type (stock, bond, etc.), amount, and current market value as of the date of the report, if applicable.
9.) **List of notes and mortgages payable** – by amounts as of the date of the report and their due dates, if applicable.
10.) **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 also show where the amounts appear on the balance sheet (such as Accounts Receivable, Notes Receivable, etc.).
11.) **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.
12.) **The percentage of occupancy** – by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods the income statements cover.

If one of the above items is not available or does not apply to this provider, please explain why in the space provided below by referencing the item number followed by the explanation:

EXHIBIT 1. – Certification by Officer or Administrator of Provider(s)

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

CERTIFICATION BY OFFICER OF ADMINISTRATOR OF PROVIDER(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: _____

Officer or administrator of provider(s)

Title:_____

Date: _____

EXHIBIT 2. – Cash Flow Statement Period Covered

CASH FLOW STATEMENT FOR THE PERIOD _____

Cash provided by:	
Operations (net)	$XXXX
Cash donations (unrestricted)	XXXX
Long-term borrowing	XXXX
Investment earnings (cash dividends, interest)	XXXX
Sale of long-term investments	XXXX
Sale of equipment	XXXX
Issuance of bonds	XXXX
Decrease in current assets – other than Accounts Receivable, Prepaid Expenses and Inventory	XXXX
Increase in current liabilities – other than Accounts Receivable, Prepaid Expenses and Inventory	XXXX
Others	XXXX
Total Cash Provided	$XXXX
Cash applied to:	
Purchase of equipment	$XXXX
Payment of long-term debt	XXXX
Payment of bond redemption fund	XXXX
Purchase of long-term investments	XXXX
Payment of dividends	XXXX
Purchase of land and/or building (purchase price less mortgage, capital stock and noncash assets given toward purchase)	XXXX
Increases in current assets – other than Accounts Receivable, Prepaid Expenses and Inventory	XXXX
Decreases in current liabilities – other than Accounts Payable and Prepaid Income	XXXX
Other	XXXX
Total Cash Applied	XXXX
Increase (Decrease) in Cash	$XXXX
Cash at end of period (MM/DD/YY)	$XXXX
Less Cash at beginning of period (MM/DD/YY)	XXXX
Increase (Decrease) in cash	XXXX

EXHIBIT 3. – Projected Cash Flow Statement Cash from Operations Period Covered

PROJECTED CASH FLOW CASH FROM OPERATIONS

FOR THE PERIOD _____

Net Income (or Net Loss)	$XXXX
Increases:	
Depreciation expense	$XXXX
Loss from sale of equipment	XXXX
Decrease in net Accounts Receivable	XXXX
Decrease in Prepaid Expense	XXXX
Decrease in Inventory	XXXX
Increase in Accounts Payable	XXXX
Increase in Prepaid Income	XXXX
Others	XXXX
Gross Cash from Operations	$XXXX
Decreases:	
Gain from sale of equipment	$XXXX
Increase in net Accounts Receivable	XXXX
Increase in Prepaid Expense	XXXX
Increase in Inventory	XXXX
Decrease in Accounts Payable	XXXX
Decrease in Prepaid Income	XXXX
Others	XXXX
Net Cash from Operations	$XXXX

The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your claim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the CMS or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.