national government SERVICES

MEDICARE

A CMS Medicare Administrative Contractor

# Low/No Utilization Cost Report Waiver

This form must be included as part of your Medicare cost report submission.
Refer to theNGSMedicare.com website for the full requirements regarding this type of submission.

Provider name _____

Provider Number(s) _____ _____

Cost report period from _____ to _____

Check one box below to indicate the type of cost report that your facility is filing:

☐ **No Utilization Cost Report** – Your signature below certifies the provider furnished no covered services *and* no claims for Medicare reimbursement will be filed for the period listed above.

☐ **Low Utilization Cost Report** – Your signature below certifies the provider will accept interimpayments as payment in full for the period listed above.

- Based on $200,000 or less Medicare Reimbursement ($50,000 RHC/FQHC) ($15,000 CMHC)

  Projected total Medicare payments $ _____

- **Only available for FYE 12/31/2016 and prior**

  Based on 10% or less Medicare Utilization

  Projected Medicare days/visits _____

  Projected Total days/visits _____

**Hospitals:** Do you have interns and residents? ☐ Yes ☐ No

(If yes, IRIS files are required to be submitted with your cost report.)

**Children's Hospital:** Verification of Age for Eligibility Form is Required

Signature _____ Date _____

Printed Name _____ Title _____

Phone _____ Email _____