WPS GHA Accelerated and Advance Payment Request

The Centers for Medicare & Medicaid Services (CMS) has expanded the Accelerated and Advance Payment Program to provide financial relief to Medicare providers/suppliers working 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 request. The completed request must be printed and signed by the provider's/supplier's authorized official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf. Digital signature is an allowed form of authorization.
- Complete all fields to prevent delays in processing.
- If you need to request a payment for more than one Medicare Identification Number (PTAN), include a separate list of each Medicare Identification Number (PTAN) and matching National Provider Identifier (NPI) with this request. This will ensure faster processing of your request. The authorized official **must** have authority to sign on behalf of all parties.
- To identify your applicable MAC and for further guidance, reference the following link: http://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
- Your MAC will notify you of the decision and when you'll receive payment to the email listed on the form.

Complete All Fields Below

Provider Name: _____

Medicare Identification Number (PTAN): _____ or ☐ list attached

NPI Number: _____ or ☐ list attached

Phone Number: _____ Fax Number: _____

Email Address: _____

Check the reason for your request (select one option below)

☐ Delay in provider/supplier billing process is an isolated temporary nature beyond the provider/supplier's normal billing cycle due to COVID-19 and not attributable to other third party payers or private patients.

☐ Other. Please explain:

Payment Amount Requested (select on 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: _____

I _____, _____, certify that I'm the
(name) (title)
authorized official that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.

Signature of authorized official listed above: _____

Date: _____