ACCELERATED PAYMENT REQUEST CERTIFICATION

I, _____, _____
(Name) (Title)
certify the validity of the request for an accelerated payment by _____
(Provider Name)
in the amount of $_____ from the Medicare Program.

Provider Number (PTAN): _____ National Provider Identifier (NPI): _____

Provider address: _____

Provider email address: _____

Specifically, I certify the accuracy of the statements checked below:

_____ I understand that Medicare is making an accelerated payment for services already provided.

_____ The provider has put forth a good faith estimate of the amount actually due for services already provided.

_____ The accelerated payment will be used to operate the provider, and will not be used for payments outside the provider's ordinary course of business.

_____ The provider is not involved in an active bankruptcy case and has no plans to file bankruptcy.

_____ The provider has no plans to cease doing business.

Check reason for request:

___ Delay in provider billing process of an isolated, temporary nature beyond the provider's normal billing cycle and not attributable to other third-party payers or private patients

___ Other, please explain: _____

Pursuant to 28 U. S. C. Section 1746, I declare under penalty of perjury that I have investigated the matters that are subject of this document, and that the information provided is true and correct.

Signed:

_____Dated: This _____day of _____,_____
(Name and Title)