SAMPLE FORMAT FOR PROVIDER REQUEST FOR ACCELERATED PAYMENT:

1. Provider:_____ Provider Number:_____
Address:_____
_____

2. Contractor: _____

3. Check (a) or (b) if applicable:

Cash balance is seriously impaired due to:

(a) Abnormal delay in Title XVIII claims processing and/or payment by the health insurance Contractor.

(b) 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.

Note: If 3b is checked the provider should also include a narrative explaining the nature of the problem, how it will be fixed, and the expected duration of the delay.

4. a. General fund cash position for provider as of _____ $_____

b. Anticipated receipts from all sources (exclusive of accelerated payments) in the next 30 days $_____

c. Anticipated expenditures in next 30 days $_____

d. Indicated cash position in next 30 days (a + b – c) $ ____