FIRST COAST SERVICE OPTIONS, INC.

Jurisdiction N - Medicare Part A and B

Accelerated and Advance Payment Request Form

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 form. The completed form must be printed and signed by the provider's/supplier's authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf. If not signed by the authorized representative, the request will be denied.
- Complete all fields to prevent delays in processing.
- If you need to request a payment for more than one Medicare Identification Number (PTAN), submit a separate form for each Medicare Identification Number (PTAN) and matching National Provider Identifier (NPI). This will ensure faster processing of your request.
- First Coast Service Options will notify you of the decision and when you'll receive payment to the email listed on the form.
- Providers will have to pay back the accelerated/advance payment.

Request forms must be uploaded through our Provider Enrollment Gateway at:
https://medicare.fcso.com/Enrollment/EnrollmentGateway.asp

Our Gateway entry page includes a help guide on accessing the tool and submitting your request form.
Only PDF formats are accepted on the Gateway.

Provider Name:	Phone Number:
Medicare Identification Number (PTAN):	Fax Number:
NPI:	Email Address:

Select one option below	Check the reason for your request
☐	Delay in provider/supplier billing process is of 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

Select one option below	Payment Amount Requested
☐	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 _____ (Name), _____ (Title), certify that I'm the authorized representative that is legally able to make financial commitments and assume financial obligations on the provider's/supplier's behalf.

Signature of authorized representative listed above:	Date:

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