

**An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR 421.214 are met. An advance payment may be made if all of the following conditions are met:**

- The carrier is unable to process the claim timely.
- CMS determines that the prompt payment interest provision specified in section 1842© of the Act is insufficient to make a claimant whole.
- CMS approves, in writing to the carrier, the making of an advance payment by the carrier.

**Advance payments are not made to any supplier that meets any of the following conditions:**

- Is delinquent in repaying a Medicare overpayment.
- Has been advised of being under active medical review or program integrity investigation.
- Has not submitted any claims.
- Has not accepted claims' assignments within the most recent 180-day period preceding the system malfunction.

If the Provider meets the above criteria, please fill out the following forms.

**All Fields are REQUIRED**

Contract (select one)

- JE-Part A** or  **JF-Part A**    **Fax:** 701-277-6572 or **Email:** JE-reimb@noridian.com or JF-reimb@noridian.com
- JE-Part B** or  **JF-Part B**    **Fax:** 701-277-7865 or **Email:** PartBadvancepayments@noridian.com
- JA-DME** or  **JD-DME**    **Fax:** 701-277-7892 or **Email:** dmemsprecoupment@noridian.com

Provider Name:

Contact Name (Please print)

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Provider Number (PTAN)

National Provider Identifier (NPI)

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Phone Number

Fax Number

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Email Address

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Address

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Current Monthly Billing Amount

Total Amount Requests

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Reason for Hardship:

I, \_\_\_\_\_, \_\_\_\_\_,  
(Name) (Title, Must be CFO or higher)

certify the validity of the request for an advance payment in the amount of \$ \_\_\_\_\_  
from the Medicare Part B Program.

Business Name \_\_\_\_\_

Provider Number \_\_\_\_\_ NPI: \_\_\_\_\_

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

- I understand that Medicare is making an advance payment for services already provided.
- The provider has put forth a good faith estimate of the amount actually due for services already provided.
- The advance payment will be used to operate the Provider's business and will not be used for payments outside of the Provider's ordinary course of business as an operating facility.
- The Provider has no plans to file for bankruptcy.
- The Provider has no retained bankruptcy counsel.
- The Provider has no plans to cease doing business.

In signing for the Provider, and myself, I understand that false statements are punishable as felony under 18 U.S.C.1001, which provides as follows:

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title, or imprisoned not more than five years, or both.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*I certify that I am an authorized representative that is legally able to make financial commitments and assume financial obligation on the provider's behalf.*