**Requests for Cyber Related Incident (CRI) Accelerated Payments to Part A Providers**
**_____ (Provider System/ LBN)**

**Please note, providers receiving Periodic Interim Payments are not eligible to receive Accelerated Payments. However, Skilled Nursing Facilities receiving interim payments as described in 42 CFR §413.350(c) and is not receiving PIP payments under 42 CFR §413.350(b), may request accelerated payments.**

| | | | | |
|---|---|---|---|---|
| Provider Legal Business Name | | Medicare Identification Number (PTAN) | | |
| National Provider Identification Number (NPI) | | Tax Identification Number (TIN) | | |
| Authorized Official Name | | Title of Authorized Official | | |
| Address | | City | | |
| State | | Zip | | |
| Contact Email | | Contact Phone Number | | |

*Multiple submissions Attachment?:* ☐Yes ☐ No

For Authorized Representatives submitting multiple NPI/PTAN combinations please a complete list with the following information:

- Legal Business Name
- NPI
- PTAN
- TIN
- Amount requested or "Maximum" based on the options below.

## Authorized Official Certification

By initialing and signing below, I attest that I am the authorized official that is legally able to make financial commitments and assume financial obligation on the provider's behalf and certify that on best knowledge, information, and belief that any required documentation furnished as part of this request, including the certifications and acknowledgements below, is accurate, complete, and truthful.

For Authorized Officials submitting multiple NPI/PTAN combinations: I attest that I am the authorized official that is legally able to make financial commitments and assume financial obligation on behalf of all NPI/PTANs that I am submitting. I certify that on my best knowledge, information, and belief that any required documentation furnished as part of this request, including the certifications and acknowledgements below, is accurate, complete, and truthful.

**Certification of Facts:**

_____ (Initials) I certify that the provider(s) for which I am requesting an accelerated payment has been unable to submit Medicare claims or receive Medicare claims payments due to the Cybersecurity Breach which occurred on or about _____, 20____ and was reported to the appropriate authorities and/ or agencies on _____, 20____ ("the Incident").

_____ (Initials) I certify that the following systems were compromised and/or taken out of operation to address the Incident.

System:_____ Purpose: _____

System:_____ Purpose: _____

System:_____ Purpose: _____

*If additional space is required, please attach to this form. Attachment?:* ☐Yes ☐ No

_____ (Initials) I certify that the Incident mitigation efforts to restore data systems are underway to reestablish electronic billing processes. (For example, there is assigned personnel actively working to restore systems, etc.)

_____ (Initials) I certify that the provider has experienced a disruption in Medicare claims payment or submissions due to the Incident, and such disruption is a result of the Incident.

_____ (Initials) I certify that the provider has been unable to obtain sufficient funding from other available sources to cover the disruption in claims payment, processing, or submission attributable to the Incident.

_____ (Initials) I certify that the provider does not intend to cease business operations and presently is not insolvent.

_____ (Initials) I certify that if the provider currently is in bankruptcy, then it will send case information about the bankruptcy to CMS.

_____(Initials) I certify that the provider is enrolled in the Medicare program and has not been revoked, deactivated, precluded, or excluded by CMS or OIG.

_____ (Initials) I certify that the provider does not owe the Medicare program any delinquent debts.

_____ (Initials) I certify that the provider does not currently have a payment hold or payment suspension associated with their Medicare provider billing agreement and/or billing number (PTAN).

_____ (Initials) I certify that based on its best information, knowledge, and belief, the provider is not aware that the provider or a parent, subsidiary, or related entity of the provider is under an active healthcare-related program integrity investigation in which the provider or a parent, subsidiary, or related entity of the provider: (1) is under investigation for potential False Claims Act violations related to a federal healthcare program; (2) is a defendant in state or federal civil or criminal action (including a qui tam False Claims Act action either filed by the Department of Justice (DOJ) or in which DOJ has intervened); or (3) has been notified by a state or federal agency (including a state or federal prosecutor, the HHS Office of Inspector General, or the Centers for Medicare & Medicaid Services (including its contractors, such as the Unified Program Integrity Contractors)), that it is a subject of a civil or criminal investigation or Medicare program integrity administrative action (e.g.: revocation of enrollment or payment suspension); or (4) has been notified that it is the subject of a program integrity investigation by a licensed health insurance issuer's special investigative unit (or similar entity).

_____ (Initials) I certify that the provider will use the funds received for operations of the specific provider for which the funds were requested.

**Acknowledgement of Terms of Accelerated Payments:**

_____ (Initials) I acknowledge that any accelerated payment granted as a result of the Incident represents an advance on claims payments and is extended directly from the Medicare Trust Funds.

_____ (Initials) I acknowledge that accelerated payments are not loans. They cannot be forgiven, and indebtedness cannot be reduced. There are no flexibilities available regarding the repayment timelines and CMS will use its standard recoupment procedures to recover these amounts.

_____ (Initials) I acknowledge that CMS will proceed directly to issuing a demand letter to recover any accelerated payment in full if any information furnished in this request has been falsely attested, acknowledged, or certified.

_____ (Initials) I acknowledge that the availability of accelerated payments as a result of this Incident is not guaranteed, and payments will not be issued once the disruption to claims servicing related to the Incident is remediated, regardless of when the request is received.

_____ (Initials) I acknowledge that CMS maintains the right to conduct post payment audits related to any accelerated payments issued under this program.

_____ (Initials) I acknowledge that the provider may only submit one request for accelerated payments, and the issuance of such payment is dependent on the duration of the Incident, and the extent to which the Incident has disrupted the submission and/or processing of Medicare claims payments.

_____ (Initials) I acknowledge that any funds issued under the accelerated payment program for the Incident will be recouped at 100% offset of claims payments for a period of 90 days immediately following the date on which payments were issued to the requested entities.

_____ (Initials) I acknowledge that an overpayment demand letter will be issued for any remaining funds, which are not fully repaid within 90 days, on the 91st day following the issuance of the accelerated payment.

_____ (Initials) I acknowledge that any debt demanded as a result of an outstanding balance of any accelerated payment granted as a result of the Incident will accrue interest at the rate specified in 42 CFR 405.378.

_____ (Initials) I acknowledge that granting of accelerated payments by CMS is discretionary, and CMS may decline a request under the accelerated payment program at any time and any declination is not appealable.

_____ (Initials) I acknowledge that the provider understands that the acceptance of payments under the accelerated program means that the provider expressly relinquishes any and all rights to appeal any resulting overpayment determinations issued for the recovery of these amounts, whether formally or informally and whether administratively or judicially.

**Payment Amount Requested**

- ◯ I am requesting the maximum amount eligible, as calculated by CMS for accelerated payments issued as a result of this Incident. This amount shall not exceed the average value of thirty (30) days of claims payments using the claims payment history for a 90-day period preceding the date of the incident.
- ◯ I am requesting less than the maximum payment amount as calculated by CMS (enter requested amount) $_____

**Authorized Representative Signature: _____**

**Printed Name: _____ Date: _____**

**Official Title: _____**

Please complete this template and submit via e-mail CGS.ERS.CORR@cgsadmin.com, fax 1.615.664.5949 or mail to:

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