

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.

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 has no plans to file bankruptcy.

The provider has no plans to cease doing business.

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

Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willingly 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.

Signed: _____ Dated: This _____ day of _____,
(Name and Title)

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)