

Nursing Facility Request for Expedited Payment - November 2008

Please fill out this form to request an expedited payment for services to be provided from November 17, 2008 through November 30, 2008. The amount you receive will be calculated by DMAP based on the amount billed for November 1 through November 16, 2008 dates of service. This amount is an estimated payment and may be different than the actual amount you bill for Nov 17 - 30, 2008.

Your request for expedited payment must be received by the Division of Medical Assistance Programs (DMAP) by November 21, 2008. Requests submitted on or before November 21, 2008 will be processed by November 28, 2008.

Provider Name: _____
Mailing Address: _____
DMAP Provider Number: _____
National Provider Identification (NPI): _____
Federal Tax ID: _____
Your Name (Authorized Representative): _____
Your Phone Number: _____
Your Email Address: _____

Deliver payment by the following method:

- Mail to address above:
Attention: _____
- Mail one time to the following address:
Attention: _____
Address: _____

Terms for Transitional Payments

I understand that:

- a) Funds will be offset and recovered beginning with the DHS next payment cycle.
- b) If I and/or my business stop providing billable services for the OHP, I will reimburse DHS any overpayment that may occur.
- c) I understand the state/federal health care program will recoup to the fullest extent of the law.

I have read and agree to the above terms.

Authorizing Signature

Title

Date

FAX OR SCAN AND EMAIL A SIGNED COPY OF THIS FORM TO

Attn: Terry Layman

FAX: (503) 945-6873, or EMAIL: terry.layman@state.or.us