Interim Provider Payments - For Fee-for-Service Providers Only

Fee-for-service providers who experience delays in their payments due to billing problems and higher than normal denied or suspended claims may request an interim provider payment by submitting an Interim Provider Payment Request Form. The form will also be available on the GAMMIS website at www.mmis.georgia.gov or by contacting HP at 1-800-766-4456. Please see Interim Provider Payments form processing instructions below. Fee-for-service providers are required to submit the information on the form for an interim provider payment to be considered. Providers will be required to attest to the billed amount of submitted claims and the conditions of the interim provider payment. Payment will be based on the lesser amount of:

- 80 percent of the billed sum of claims submitted but not paid
- 80 percent of the historical average payment totals for the payee
- The amount of the requested Interim Provider Payment

The Department of Community Health reserves the right to impose a different interim payment limitation if it is deemed necessary.

Instructions: The forms are to be submitted on a retrospective basis, meaning that prior to completing the form, the provider must wait for the issuance of their Remittance Advice to determine the outcome of their weekly claims submission. The provider is responsible for assuring that the Interim Provider Payment Request Form is signed before it is submitted. The provider may submit the Interim Provider Payment Request Form via fax or e-mail. Only one form per

Please Note: The interim provider payment will be automatically recouped when the provider's claims are later processed through the automated claims processing system and must be fully repaid in accordance with Medicaid Policy Manual, Part 1, related to Overpayment Recovery. A list of claims' ICNs must accompany the Interim Provider Payment request on a separate sheet. CMO Providers are not eligible to receive Interim Provider Payments.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid Management Information System
GAMMIS
Interim Provider Payment Request Form

All fields marked with an asterisk (*) are required. The form will not be processed without this information.

TRANSACTION TYPE

Section 1

☐ Interim Payment Request ☐ Cancel / Discontinue Interim Payment (Only Section 2 and 4 are required for cancellation)

PAYEE IDENTIFICATION

Section 2

1. Federal Tax Identification Number (TIN) *	2. Medicaid Payee Provider Number *		
3. Name of Payee *			
4. Street Address	5. City	6. State	7. Zip
8. Total Percent of Annual Revenue from Medicaid/PeachCare for Kids Programs * _____%			
9. Provider must include a separate sheet with all ICNs of claims impacted.			

CLAIM / PAYMENT INFORMATION

Section 3

1. Type of Media for the Claim Submission *

☐ Paper ☐ Web Portal ☐ PES Software ☐ 837 Health Care Claim Electronic Transaction

2. Enter the one week period (Saturday thru Friday) that the below claim information pertains to (example 11/06/2010 thru 11/12/2010) *

From: To:

3. Number of Claims (if known) Not Processed thru the GAMMIS or Denied in Error for the Week

4. Billed Amount of Claims Not Processed thru the GAMMIS or Denied in Error for the Week *

5. Total Payment received (if any) this week *

6. Total Interim Payment Amount Requested for the Week *

7. Description of Billing or Processing Issues Causing Payment Delay *

8, Rendering Providers for which interim payment is requested (optional). This information can be used by the Payee to allocate the payment received, but will NOT be used by DCH to allocate specific recovery amounts.

Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount
Rendering Provider	Medicaid Provider ID	Amount

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid Management Information System
GAMMIS
Interim Provider Payment Request Form (continued)

CONTACT INFORMATION FOR THE PERSON PREPARING THE FORM

Section 4

1. Contact Name *	2. Printed Name *
3. Email Address	4. Business Phone Number *

FAX OR EMAIL FORM TO:

Section 5

1. Fax Number: 770-344-4200	2. Email Address: stlemcani@dch.ga.gov imuhammad@dch.ga.gov

ATTESTATION

Section 6

PAYEE attests that the charges listed above have been submitted and not paid, that each service has been billed only once, and that the information is truthful and accurate.

PAYEE attests to, and understands that, the interim payment will be automatically recouped when the provider's claims are later processed through the automated claims processing system and even if the interim payment is not automatically recouped, the payee must fully repay the interim payement in accordance with Medicaid Policy Manual, Part 1, related to Overpayment Recovery.

1. Authorized Signature *	2. Printed Name *	
3. Title of Authorized Person *	4. Business Phone Number ^	5. Date *

-- FOR DCH USE ONLY --

Section 7

1. Request Processed by		2. Date Processed
3. Payment Approved ☐ YES ☐ NO	4. If Approved, Payment Amount	5. Payment Method ☐ OCP ☐ RP
	4. If Denied, Reason	