Part A Prior Authorization Request Coversheet

Jurisdiction: E F

Number of Pages *(Including coversheet)*: _____

Expedited request? Yes No

If yes, expedited request justification required:

_____

Request date: _____

Request name: _____

Requestor phone: _____ Ext. _____

Requestor email address: _____

Requestor fax number: _____

Requestor address: _____

Requestor city, street zip: _____

Physician/practitioner name: _____

Physician/practitioner PTAN: _____

Physician/practitioner NPI: _____

Physician/practitioner Fax: _____

Physician/practitioner address: _____

Physician/practitioner city, state, zip: _____

☐ Initial Request ☐ Resubmission (*Add prev. UTN*)

Previous UTN: _____

Facility name: _____

Facility PTAN: _____

Facility NPI: _____

Facility address: _____

Facility city, street zip: _____

Procedure code: _____

Diagnosis code: _____

Type of bill: _____

Units of service: _____

Anticipated date of service: _____

Medicare beneficiary ID *(MBI)*: _____

Beneficiary name: _____

Beneficiary date of birth: _____

Noridian Medicare Portal:
www.noridianmedicareportal.com

Fax to:
701-277-2903

JE Mail to:
Noridian Healthcare Solutions
PO Box 6782
Fargo, ND 58108-6742

JF Mail to:
Noridian Healthcare Solutions
PO Box 6722
Fargo, ND 58108-6742

For additional information such as the medical policy, visit our website at:
JF – https://med.noridianmedicare.com/web/jfa/cert-reviews/pre-claim
JE – https://med.noridianmedicare.com/web/jea/cert-reviews/pre-claim

Print Form

Previous UTN: _____ Beneficiary date of birth:

A CMS Medicare Administrative Contractor