noridian
Healthcare Solutions

General Written Inquiries Form - Medicare Part A

This form can be used for any general provider inquiry that is not an available option on any other form.

Helpful Hints

1. ONE REQUEST FORM PER BENEFICIARY AND/OR ISSUE.
2. For Claim/Tracer questions, address or assignment changes, call 1-855-609-9960.
3. Rejected claims and/or lines should be corrected through Direct Data Entry (DDE). When submitting a new UB04 form for claim processing, please do not include a coversheet or documentation with the form.
4. **Do not use this form for Medicare Secondary Payer (MSP), Recoupment or Redetermination Requests.**

Provider Contact Information

Provider Name: ______________________________

Provider Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Contact Person: ______________________________ Phone Number: ______________

Provider Transaction Access Number (PTAN): ______________________________

National Provider Identifier (NPI): ______________ TAX ID: ______________

Patient Information

Patient Name: ______________________________

Date of Birth: ______________ Phone Number: ______________

Medicare Number: ______________________________

Date(s) of Service(s): ______________________________

HCPCS/Procedure Codes: ______________ Document Control Number (DCN): ______________

Reason for Inquiry Request

Please select one of the following and provide comments if needed.

- ☐ W-9 Request
- ☐ Fee Schedule
- ☐ Crossover Question
- ☐ Regulations & Coverage
- ☐ General Billing
- ☐ Other

Comments

Fax documents to 701-277-7852

Medicare Part A

Attn: Claims Inquiries

PO Box

Fargo, ND 58108 -

State and PO Box Numbers

AS 6773	HI 6773
CA 6770	MP 6773
GU 6773	NV 6772

Print Form