

The Noridian Medicare Portal (NMP) may be accessed to review claim status.
Please allow 45 calendar days for MSP to complete a request submitted on this form.

Instructions:

Please complete this form and include it with the submission.
Each submission should include a completed form and the primary explanation of benefits (if applicable).
If multiple patients or multiple claims for the same patient, submit separate forms.

Do Not Use this Form for the Following:

- Refund checks
- Requesting a Redetermination on an MSP claim for a reason unrelated to MSP
- New claim submissions\CMS-1450 form (UB-04)
- Situations that involve the Veteran’s Administration, PACMED or USFHP (US Family Health Plan)

Reason for Request

- Not related to no-fault/workers’ comp/liability/Medicare Set-Asides
- Medicare paid primary in error
- Medicare paid secondary in error
- Other _____

Patient and Claim Information	Primary Insurance Information	Provider Information
Patient Name	Insurance Name (If Applicable)	Provider Name
Medicare Beneficiary Identifier (MBI)	Insurance Address	Provider Address
Claim Number(s) (DCN)	Subscriber Name (If Applicable)	Provider Phone Number
Claim Start Date of Service	Subscriber Relationship (If Applicable)	National Provider Identifier (NPI)
Claim End Date of Service	Policy Number	Provider Number (PTAN)
Claim Amount	Effective Date/Term Date	Tax Identification Number (TIN)
	Injury Date (If Applicable)	
	Injury Diagnosis Codes (If Applicable)	

Please send to:

Medicare Part A
Attn: MSP
PO Box _____
Fargo, ND 58108-_____
Provider Contact Center (PCC) 1-855-609-9960
Or Fax to 701-277-7852

State and PO Box Numbers:

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

