noridian
Healthcare Solutions

Medicare Secondary Payer Part B Form

Please complete and forward this form to Noridian.
Helpful Hints:

- If you are sending a refund check, please use the Medicare Part B MSP Voluntary Checks Form.
- This form may be utilized for any Medicare Secondary Payer (MSP) request pertaining to Primary or Secondary payment of claims.
- Please forward all inquiries for MSP Recovery to the BCRC.
- Do not include a refund check with this form.
- Do not use this form if you are requesting a Redetermination on a MSP claim that is not MSP related.
- Do not use this form for new claim submissions.
- Do not use this form for situations that involve the Veteran's Administration, PACMED or USFHP (US Family Health Plan). Use Reopenings Form.

Provider/Physician/Supplier or Other Entity Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

NPI/Tax ID/PTAN: _____

Contact Person: _____ Phone #: _____

Provide the following information for **each** claim:

Patient Name: _____ Medicare Number: _____

Medicare Claim # (ICN): _____ Claim Amount: $ _____

Date of Service: _____

Reason for Request: _____

Select Reason Code for Claim Adjustment

- ❑ 12 Working Aged
- ❑ 13 End Stage Renal Disease
- ❑ 14 Auto No Fault Insurance
- ❑ 15 MSP Workers Compensation*
- ❑ 16 Federal
- ❑ 19 Workers Compensation Medical Set Aside
- ❑ 41 Black Lung
- ❑ 43 Disability Insurance
- ❑ 47 Liability Insurance

MEDICARE SECONDARY PAYER: Complete the following primary insurance information and attach a copy of the primary payer Explanation of Benefits (EOB) or payment sheet, and/or a copy of the check received from the primary payer and the Medicare EOB.

Insurance Name: _____ Subscriber Name: _____

Insurance Address: _____ Subscriber Relationship: _____

City, State, Zip: _____ Phone #: _____

Policy Number: _____ Group Number: _____ *Injury Date: _____

Effective Date: _____ Term Date: _____ Injury Diagnosis: _____

NOTE: If specific patient/Medicare Number/Claim #/primary insurance EOB information is not provided, we may be unable to process your request appropriately or in a timely manner.

Please send to:
Medicare Part B
Attn: MSP
PO Box _____
Fargo, ND 58108-_____
Or Fax to 701-277-7852

State and PO Box Numbers

AS 6777	CA-N 6774	CA-S 6775	GU 6777
HI 6777	MP 6777	NV 6776	

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES