NORIDIAN
HEALTHCARE SOLUTIONS

Medicare Part B Fax/Mail/esMD Cover Sheet

This form is only to be used when submitting **documentation associated with electronic claims already** submitted.

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN (Exactly as entered in the PWK loop on the claim) _____ICN _____

Beneficiary Last Name _____ Beneficiary First Name _____ Medicare ID_____

Date of Service: From _____ Date of Service: To _____Total Claim Billed Amount _____

Billing Provider's Name:_____

Contact's Name: _____Phone Number_____

NPI: _____PTAN: _____

State Where Services Were Provided _____Total Number of Pages (including cover sheet): _____

Comments

Provider Name and Address/Fax

Print and Return Completed Form and Documentation by:

- **Fax: 701-277-7852**

  Noridian
  PO Box 6723
  Fargo, ND 58108-6723

Print Form

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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