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**Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports**

**Medicare Part B Fax/Mail Coversheet**

*(Fields with a red asterisk (\*) are required.)*

Request Type (check one)\*:      Initial                  RESUBMISSION                  EXPEDITE

If you selected "resubmission", please provide previous UTN

If you selected "expedite", please explain why the normal time frame jeopardizes the life or health of the beneficiary. Medical documentation must also support the need for an expedited review.\*

Number of transports requested (round trip = 2 transports)\*

Start of 60-day period (mm/dd/yyyy)\*

Procedure code(s)\*                                  Modifier 1                                  Modifier 2

**Ambulance Supplier Information**

Supplier Name\*

Supplier NPI\*    Supplier PTAN

Supplier Address\*

Supplier City, State Zip\*

State where ambulance is garaged\*

**Beneficiary Information**

Last Name\*    First Name\*

Medicare Beneficiary Identifier\*

Date of Birth (mm/dd/yyyy)\*

**Certifying Physician Information**

Certifying Physician Name

Certifying Physician NPI    Certifying Physician PTAN

Certifying Physician Address

Certifying Physician City, State, Zip

**Requester/Contact Information**

Fax number (if a decision letter by fax is requested)

Contact Name    Contact Phone/Ext.

Requester Name\*    Requester Phone/Ext.\*

Requester Signature\*    Date\*

**Fax to:** 701-433-3024

**JE Mail to:**  
Noridian Healthcare Solutions (Part B Prior Authorization)  
PO Box XXXX Fargo, ND 58108-XXXX

XXXX Corresponds to:  
Northern California 6774  
Southern California 6775  
Nevada 6776  
Hawaii and Pacific Islands 6777

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