noridian
Healthcare Solutions

# Medicare Part A 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) _____ DCN _____

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 6722
  Fargo, ND 58108-6722

Print Form



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES