Noridian Healthcare Solutions

General Written Inquiries Form - Medicare Part A

This form can be used for any general provider inquiry that is not an available option on any other form.

Helpful Hints

1. ONE REQUEST FORM PER BENEFICIARY AND/OR ISSUE.
2. For Claim/Tracer questions, address or assignment changes, call 1-877-908-8431.
3. Rejected claims and/or lines should be corrected through Direct Data Entry (DDE). When submitting a new UB04 form for claim processing, please do not include a coversheet or documentation with the form.
4. **Do not use this form for Medicare Secondary Payer (MSP), Recoupment or Redetermination Requests.**

Provider Contact Information

Provider Name: ______________________

Provider Address: ______________________

City: ______________ State: ______________ Zip: ______________

Contact Person: ______________________ Phone Number: ______________

Provider Transaction Access Number (PTAN): ______________________

National Provider Identifier (NPI): ______________ TAX ID: ______________

Patient Information

Patient Name: ______________________

Date of Birth: ______________ Phone Number: ______________

Medicare Number: ______________________

Date(s) of Service(s): ______________________

HCPCS/Procedure Codes: ______________ Document Control Number (DCN): ______________

Reason for Inquiry Request

Please select one of the following and provide comments if needed.

- ☐ W-9 Request
- ☐ Fee Schedule
- ☐ Crossover Question
- ☐ Regulations & Coverage
- ☐ General Billing
- ☐ Other

Comments

Fax documents to 701-277-7852

Medicare Part A

Attn: Claims Inquiries

PO Box

Fargo, ND 58108

State and PO Box Numbers

AK 6720	OR 6726
AZ 6730	SD 6733
ID 6726	UT 6724
MN 6714	WA 6720
MT 6732	WY 6734
ND 6709	

Print Form