

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

- | | | |
|---|--|--|
| <input type="checkbox"/> 12 Working Aged | <input type="checkbox"/> 15 MSP Workers Compensation* | <input type="checkbox"/> 41 Black Lung |
| <input type="checkbox"/> 13 End Stage Renal Disease | <input type="checkbox"/> 16 Federal | <input type="checkbox"/> 43 Disability Insurance |
| <input type="checkbox"/> 14 Auto No Fault Insurance | <input type="checkbox"/> 19 Workers Compensation Medical Set Aside | <input type="checkbox"/> 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-_____
Provider Contact Center (PCC) 1-877-908-8431
Or Fax to 701-277-7852

State and PO Box Numbers

AK 6703	OR 6702
AZ 6704	SD 6707
ID 6701	UT 6725
MT 6735	WA 6700
ND 6706	WY 6708

