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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

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

XXXX Corresponds to:

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