

Part A Prior Authorization Request Coversheet

Jurisdiction: E F		Number of Pages (Inclu	iding coversheet):
Expedited request? Yes No If yes, expedited request justification requir	ed:		
Request date:		_ Facility name:	
Request name:		_Facility PTAN:	
Requestor phone:	Ext	Facility NPI:	
Requestor email address:		_ Facility address:	
Requestor fax number:		_Facility city, street zip:	
Requestor address:		_ Procedure code:	
Requestor city, street zip:		_ Diagnosis code:	
Physician/practitioner name:		_ Type of bill:	
Physician/practitioner PTAN:		_ Units of service:	
Physician/practitioner NPI:		_Anticipated date of service:	
Physician/practitioner Fax:		_	
Physician/practitioner address:		_Medicare beneficiary ID (<i>MBI</i>):	
Physician/practitioner city, state, zip:		_Beneficiary name:	
□ Initial Request □ Resubmission (Add prev. UTN)		Beneficiary date of birth:	
Previous UTN:		_	
Noridian Medicare Portal: www.noridianmedicareportal.comJE Mail to: Noridian Hea PO Box 6782 			JF Mail to: Noridian Healthcare Solutions PO Box 6722 Fargo, ND 58108-6742
For additional information such as the JF – https://med.noridianmedicare.com			Print For

Beneficiary date of birth:

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Previous UTN:



A CMS Medicare Administrative Contractor

JE - https://med.noridianmedicare.com/web/jea/cert-reviews/pre-claim