Noridian Healthcare Solutions
4510 13th Ave. S., Fargo, ND 58103

PART A PRIOR AUTHORIZATION

OUTPATIENT HOSPITAL DEPARTMENT (OPD) REQUEST COVERSHEET

Jurisdiction: E☐ F☐ Number of Pages (including coversheet): ☐

Expedited Request? Yes☐ No☐

If yes, expedited request justification required:

Request Date:_____ Facility Name:_____

Anticipated Date of Service: _____ Facility PTAN:_____

Requestor Name: _____ Facility NPI:_____

Requestor Phone: _____ Ext. _____

Requestor Email Address:_____ Facility Address: _____

Requestor Fax Number: _____ Facility City, State, Zip: _____

Requestor Address: _____ Procedure Code:_____

Requestor City, State, Zip:_____ Diagnosis Code:_____

Physician/Practitioner Name_____ Units of Service:_____

Physician/Practitioner PTAN: _____ Type of Bill:_____

Physician/Practitioner NPI:_____ Beneficiary Name: _____

Physician/Practitioner Fax: _____ Beneficiary Medicare ID: _____

Physician/Practitioner Address: _____ Beneficiary Date of Birth: _____

Physician/Practitioner City, State, Zip: _____

Initial Request☐ Resubmission☐ (*Add Previous UTN*)

Previous UTN: ☐

Noridian Medicare Portal:
www.noridianmedicareportal.com
Fax To:
701-277-2903

JE & JF Mail to:
Noridian Healthcare Solutions
PO Box 6782
Fargo, ND 58108-6782

For additional information, such as the medical policy, visit our website at:

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

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