noridian
Healthcare Solutions

Part A Prior Authorization Request Coversheet

Jurisdiction: ☐ E ☐ F

Number of Pages *(Including coversheet)*: ________________

Expedited request? ☐ Yes ☐ No

If yes, expedited request justification required:

____

Request date: ______________________________

Request name: ______________________________

Requestor phone: ____________________ Ext. ______

Requestor email address: ______________________

Requestor fax number: ________________________

Requestor address: ___________________________

Requestor city, street zip: ____________________

Physician/practitioner name: __________________

Physician/practitioner PTAN: __________________

Physician/practitioner NPI: ____________________

Physician/practitioner address: ________________

Physician/practitioner city, street zip: _____________

☐ Initial request ☐ Resubmission *(Add prev.UTN)*

Previous UTN: ______________________________

Facility name: ______________________________

Facility PTAN: ______________________________

Facility NPI: ______________________________

Facility address: ____________________________

Facility city, street zip: ______________________

Procedure code: _____________________________

Diagnosis code: _____________________________

Type of bill: ________________________________

Units of service: _____________________________

Anticipated date of service: ___________________

Medicare beneficiary ID *(MBI)*: ________________

Beneficiary name: ____________________________

Beneficiary date of birth: ______________________

Noridian Medicare Portal:
www.noridianmedicareportal.com

Fax to:
701-277-2903

JE Mail to:
Noridian Healthcare Solutions
PO Box 6782
Fargo, ND 58108-6742

JF Mail to:
Noridian Healthcare Solutions
PO Box 6722
Fargo, ND 58108-6742

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

Print Form

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