

**PART B PRIOR AUTHORIZATION****AMBULATORY SURGICAL CENTER (ASC) 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. \_\_\_\_\_ Facility Address: \_\_\_\_\_  
Requestor Email Address: \_\_\_\_\_ Facility City, State, Zip: \_\_\_\_\_  
Requestor Fax Number: \_\_\_\_\_ Procedure Code: \_\_\_\_\_  
Requestor Address: \_\_\_\_\_ Units of Service: \_\_\_\_\_  
Requestor City, State, Zip: \_\_\_\_\_ Place of Service: \_\_\_\_\_  
Physician/Practitioner Name: \_\_\_\_\_ Type of Service: \_\_\_\_\_  
Physician/Practitioner PTAN: \_\_\_\_\_ Provider Specialty Code: \_\_\_\_\_  
Physician/Practitioner NPI: \_\_\_\_\_  
Physician/Practitioner Fax: \_\_\_\_\_ Medicare Beneficiary ID (MBI): \_\_\_\_\_  
Physician/Practitioner Address: \_\_\_\_\_ Beneficiary Name: \_\_\_\_\_  
Physician/Practitioner City, State, Zip: \_\_\_\_\_ Beneficiary Date of Birth: \_\_\_\_\_

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

Previous UTN: \_\_\_\_\_

**Noridian Medicare Portal:**[www.noridianmedicareportal.com](http://www.noridianmedicareportal.com)**Fax To:**

701-433-3024

**JE MAIL TO:**

Noridian Healthcare Solutions

PO Box 6774

Fargo, ND 58108-6774

**JF MAIL TO:**

Noridian Healthcare Solutions

PO Box 6700

Fargo, ND 58108-6700

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

- JF [-https://med.noridianmedicare.com/web/jfb/cert-reviews/pre-claim](https://med.noridianmedicare.com/web/jfb/cert-reviews/pre-claim)
- JE [-https://med.noridianmedicare.com/web/jeb/cert-reviews/pre-claim](https://med.noridianmedicare.com/web/jeb/cert-reviews/pre-claim)

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