

This form is only to be used when submitting **documentation associated with electronic claims already** submitted.

**Complete all fields** and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN (Exactly as entered in the PWK loop on the claim) \_\_\_\_\_ CCN \_\_\_\_\_

Beneficiary Last Name \_\_\_\_\_ Beneficiary First Name \_\_\_\_\_ Medicare ID \_\_\_\_\_

Date of Service: From \_\_\_\_\_ Date of Service: To \_\_\_\_\_ Total Claim Billed Amount \_\_\_\_\_

Billing Provider's Name: \_\_\_\_\_

Contact's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

NPI: \_\_\_\_\_

State Where Services Were Provided \_\_\_\_\_ Total Number of Pages (including cover sheet): \_\_\_\_\_

Comments

Provider Name and Address/Fax

**Print and Return Completed Form and Documentation by:**

- **Fax: 701-277-7880**  
Noridian  
PO Box 6736  
Fargo, ND 58108-6736

**Print Form**

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