

Prior Authorization Request Coversheet

Policy Group: Pressure Reducing Support Surfaces (PRSS)

Request Date: _____ Number of Pages (including coversheet): _____

HCPCS: _____ Initial Request or Resubmission

Will you be providing an upgraded item to the beneficiary: Beneficiary Name: _____

Yes – from HCPCS _____ Medicare Beneficiary ID (MBI): _____

to HCPCS _____

No Upgrade Beneficiary State of Residence: _____

Supplier Point of Contact: _____ Beneficiary Date of Birth: _____

Supplier Name: _____ **Submitter:** Supplier or Beneficiary

Supplier Address: _____ **Decision Letters:**

Supplier Phone: _____ EXT _____ Beneficiary Request Decision Letter

Supplier Fax: _____ Clinician Request Decision Letter

Supplier NSC: _____ The clinician must be able to demonstrate a legitimate, specific need for information requested and provide a valid address to send the letter

Supplier NPI: _____ CMS sample decision request letter can be found [here](#)

Expedited Request? Yes No **Note:** *Expedited Requests Require justification to meet expedited requirements.*

Expedited Request Justification:

Fax to:
701-277-7891

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

PRSS Documentation:

- Written Order Prior To Delivery
- Documentation showing support surface is for wound management
- Care plan showing comprehensive ulcer treatment program
- Additional medical records to support medical necessity

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

JA - <https://med.noridianmedicare.com/web/jadme/cert-reviews/mr/prior-authorization>

JD - <https://med.noridianmedicare.com/web/jddme/cert-reviews/mr/prior-authorization>

Print Form

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