

Prior Authorization Request for Durable Medical Equipment Coversheet

Request Date: _____ Number of Pages Including Coversheet: _____ HCPCS Code: _____

Submission Type

Initial

Resubmission

Expedited Review

If an expedited review is requested please provide rationale: _____

Beneficiary Information

Name: _____ Medicare ID: _____

Date of Birth: _____ State of Residence: _____

Supplier Information

Name: _____ NPI: _____ PTAN: _____ Address: _____

Phone: _____ Fax: _____ Point of Contact: _____

Treating Practitioner Information

Name: _____ NPI: _____ Phone: _____

Fax: _____ Address: _____

Documentation Requirements

Use the links below to access documentation requirements:

JA

[Prior Authorization for Lower Limb Prosthetics](#)

[Prior Authorization for Power Mobility Devices](#)

[Prior Authorization for Pressure Reducing Support Surfaces](#)

JD

[Prior Authorization for Lower Limb Prosthetics](#)

[Prior Authorization for Power Mobility Devices](#)

[Prior Authorization for Pressure Reducing Support Surfaces](#)

Decision Letter Request:

Beneficiary Letter

Treating Practitioner (Must include [decision letter request](#) form with PAR submission)

Submission Options:

Noridian Medicare Portal:

www.noridianmedicareportal.com

Fax to: 701-277-7891

Mail to:

Noridian Healthcare Solutions

PO Box 6742

Fargo, ND 58108-6742