Prior Authorization Request for Durable Medical Equipment Coversheet

Request Date: _____ Number of Pages Including Coversheet: _____

HCPCS Code: _____ LT ☐ RT ☐ Review eligible voluntary accessory HCPCS codes for prior authorization: Yes ☐ No ☐

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
Prior Authorization for Orthoses

JD

Prior Authorization for Lower Limb Prosthetics
Prior Authorization for Power Mobility Devices
Prior Authorization for Pressure Reducing Support Surfaces
Prior Authorization for Orthoses

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

A CMS Medicare Administrative Contractor