

Advance Determination of Medicare Coverage (ADMC) Coversheet – Jurisdiction D

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

HCPCS: _____ Initial Request or Resubmission

Supplier Point of Contact: _____ Will you be providing an upgraded item to the beneficiary:

Supplier Name: _____ Yes – From HCPCS: _____

Supplier Address: _____ to HCPCS: _____

_____ No

Supplier Phone: _____ Beneficiary Name: _____

Supplier Fax: _____ Medicare Beneficiary ID (MBI): _____

Supplier NPI: _____ Beneficiary State of Residence: _____

Supplier NSC: _____ Beneficiary Date of Birth (DOB): _____

Fax to:
701-277-7890

Mail to:
Noridian Healthcare Solutions
Jurisdiction D Medical Review - ADMC
PO Box 6727
Fargo, ND 58108-6727

- Documentation for Manual Wheelchairs:**
- Standard Written Order
 - LCMP Specialty Evaluation
 - Financial Attestation Statement
 - Evidence of RESNA ATP involvement and certification
 - Medical records to support medical necessity

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