NORIDIAN
HEALTHCARE SOLUTIONS

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

Request Date: _____

HCPCS: _____

Supplier Point of Contact: _____

Supplier Name: _____

Supplier Address: _____

_____

Supplier Phone: _____

Supplier Fax: _____

Supplier NPI: _____

Supplier NSC: _____

Number of Pages (including coversheet): _____

☐ Initial Request or ☐ Resubmission

Will you be providing an upgraded item to the beneficiary:

☐ Yes – From HCPCS: _____

to HCPCS: _____

☐ No

Beneficiary Name: _____

Medicare Beneficiary ID (MBI): _____

Beneficiary State of Residence: _____

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

Print Form

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES