

Request Date: _____	Number of Pages (including coversheet): _____
HCPCS: _____	<input type="checkbox"/> Initial Request or <input type="checkbox"/> Resubmission
Supplier Point of Contact: _____	Will you be providing an upgraded item to the beneficiary:
Supplier Name: _____	<input type="checkbox"/> Yes – From HCPCS: _____
Supplier Address: _____	to HCPCS: _____
_____	<input type="checkbox"/> 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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