

## Advance Determination of Medicare Coverage (ADMC) Coversheet – Jurisdiction A

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: \_\_\_\_\_  
to HCPCS: \_\_\_\_\_

Supplier Address: \_\_\_\_\_  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 A Medical Review – ADMC  
PO Box 6780  
Fargo, ND 58108-6780

**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

This information is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone confirming the destruction of the information.