

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 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.