NORIDIAN
HEALTHCARE SOLUTIONS

Medicare Secondary Payer DME Form (JA)

Please complete and forward this form to Noridian.
Helpful Hints:

- If you are sending a refund check, please use the Medicare DME MSP Overpayment Refund Form.
- This form may be utilized for any Medicare Secondary Payer (MSP) request pertaining to Primary or Secondary payment of claims.
- Please forward all inquiries for MSP Recovery to the BCRC.
- Do not include a refund check with this form.
- Do not use this form if you are requesting a Redetermination on a MSP claim that is not MSP related.
- Do not use this form for new claim submissions.
- Do not use this form for situations that involve the Veteran's Administration, PACMED or USFHP (US Family Health Plan). Use Reopenings Form.

Supplier Name: ____________________

Address: ____________________ City: ____________________ State: _____ Zip Code: __________

NPI/Tax ID/PTAN: ____________________

Contact Person: ____________________ Phone #: ____________________

Provide the following information for each claim:

Patient Name: ____________________ Medicare #: ____________________

Claim Control # (CCN): ____________________ Claim Amount: $ ____________________

Date of Service: ____________________

Reason for Request: ____________________

Select Reason Code for Claim Adjustment

❑ 12 Working Aged
❑ 13 End Stage Renal Disease
❑ 14 Auto No Fault Insurance
❑ 15 MSP Workers Compensation*
❑ 16 Federal
❑ 19 Workers Compensation Medical Set Aside
❑ 41 Black Lung
❑ 43 Disability Insurance
❑ 47 Liability Insurance

MEDICARE SECONDARY PAYER: Complete the following primary insurance information and attach a copy of the primary payer Explanation of Benefits (EOB) or payment sheet, and/or a copy of the check received from the primary payer and the Medicare EOB.

Insurance Name: ____________________ Subscriber Name: ____________________

Insurance Address: ____________________ Subscriber Relationship: ____________________

City, State, Zip: ____________________ Phone #: ____________________

Policy Number: ____________________ Group Number: ____________________ *Injury Date: ____________________

Effective Date: ____________________ Term Date: ____________________ Injury Diagnosis: ____________________

NOTE: If specific patient/HIC/Claim #/primary insurance EOB information is not provided, we may be unable to process your request appropriately or in a timely manner.

Please send to:
Medicare DMEA
Attn: MSP
PO Box 6780
Fargo, ND 58108-6780
Supplier Contact Center (SCC) 866-419-9458
Or Fax to 701-277-7892

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