Noridian Healthcare Solutions
4510 13th Ave. S., Fargo, ND 58103

PART A INPATIENT REHABILITATION FACILITY

REVIEW CHOICE DEMONSTRATION (RCD) REQUEST COVERSHEET

Demonstration currently for the state of California only

Complete **ONE (1)** Medicare Submission Cover Sheet for each pre-claim review request for which documentation is being submitted.

Number of Pages (including coversheet): _____

REQUESTOR INFORMATION

Request Date: _____
IRF Admission Date: _____
Requestor Name: _____
Requestor Phone: _____ **Ext.** _____
Requestor Email Address: _____
Requestor Fax Number: _____
Requestor Address: _____

_____
Requestor City, State, Zip: _____

FACILITY INFORMATION

Facility Name: _____
Facility PTAN/CCN: _____
Facility NPI: _____

Facility Address: _____
Facility City, State, Zip: _____

BENEFICIARY INFORMATION

Beneficiary Name: _____
Beneficiary Medicare ID (MBI): _____
Beneficiary Date of Birth: _____

PRACTITIONER INFORMATION

Practitioner Name: _____
Practitioner PTAN: _____
Practitioner NPI: _____
Practitioner Fax: _____
Practitioner Address: _____
Practitioner City, State, Zip: _____

☐ **Initial Request OR Resubmission** ☐
Previous UTN: _____

Noridian Medicare Portal:
https://www.noridianmedicareportal.com

Fax To: 701-282-1479

JE (CALIFORNIA) MAIL TO:
Noridian Healthcare Solutions
Attn: Part A IRF RCD
PO Box 6770
Fargo, ND 58108-6770

CERTIFIED/COURIER MAILINGS:
Noridian JE Part A
Attn: Part A IRF RCD
4510 13th Ave S
Fargo, ND 58103

For **additional information, such as the medical policy, visit our website at:**
https://med.noridianmedicare.com/web/jea/cert-reviews/review-choice-demonstration

A CMS Medicare Administrative Contractor
Noridian Healthcare Solutions, LLC

PART A REVIEW CHOICE DEMONSTRATION (RCD) FAX COVERSHEET

Summary of Required Part A RCD Fax Coversheet Fields and Their *Purpose*

Requestor Information

Request Date: Date of submission

IRF Admission Date: Date officially admitted to the IRF as an inpatient, based on a valid physician admission order

Requestor Name/Phone/Email Address/Fax Number/Address: Individual submitting request. Provide contact details for direct follow-up.

Physician/Practitioner Information

Physician/Practitioner Name/Fax/Address: Rehabilitation provider/practitioner information

Physician/Practitioner PTAN: Rehabilitation provider/practitioner Medicare Provider Number

Physician/Practitioner NPI: Rehabilitation provider/practitioner 10-digit national ID

Facility Information

Facility Name/Address: Requesting IRF

Facility PTAN/CCN: Medicare Provider Transaction Access Number for the IRF. Confirms Medicare Enrollment and is used for billing, reporting, compliance and quality programs under the IRF Prospective Payment System (IRF PPS).

Facility NPI: 10-digit National Provider Identifier for the IRF. Required for billing and electronic transactions.

BeneficiaryInformation

****Beneficiary Name/DOB:*** Patient name exactly as on Medicare ID card

Beneficiary Medicare ID: Patient's Medicare identification number

Beneficiary Date of Birth: Patients' Date of Birth

Type of Bill:

Type of Bill: 11X. First digit is *Type of Facility* (hospital), second digit is *Type of Care* (inpatient Part A) third digit is *Frequency* (X= Void/Cancel a Prior Abbreviated Encounter Submission)

Request Type/Previous UTN:

Initial Request: Check if this is a first-time request

Resubmission: Check if resubmitting and provide previous Unique Tracking Number (UTN)

** If the name on medical documentation differs from the Medicare ID card, include a demographic sheet showing the legal name (as on the card), any prior or alternate names, date of birth, and Medicare ID. To change a legal name, update records with SSA first, then request a new card or print one via 1-800-MEDICARE or online portal.*