noridian
Healthcare Solutions

Medicare Secondary Payer Part A Form

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

- This form may be utilized for any Medicare Secondary Payer (MSP) request pertaining to Primary or Secondary payment of claims.
- This form is used when you need assistance canceling or adjusting a previous claim submission.
- Please forward all inquiries for MSP Recovery to the BCRC.
- Do not include a refund check with this form.
- Do not use this form for new claim submissions.
- Do not use this form if you are requesting a Redetermination on a MSP claim that is not MSP related.
- Do not send a UB Claim Form with this form.

Provider/Physician/Supplier or Other Entity Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

NPI/Tax ID/PTAN: _____

Contact Person: _____ Phone #: _____

Provide the following information for **each** claim:

Patient Name: _____ Medicare Number : _____

Medicare Claim # (ICN): _____ 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/Medicare Number/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 Part A
Attn: MSP
PO Box _____
Fargo, ND 58108-_____
Provider Contact Center (PCC) 1-877-908-8431
Or Fax to 701-277-7852

State and PO Box Numbers

WA 6720	AK 6720	SD 6733
ID 6726	AZ 6730	WY 6734
OR 6726	MT 6732	UT 6724
ND 6709		

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES