Medicare Part B PWK Fax/Mail Cover Sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN (Exactly as entered in the PWK loop on the claim)				DCN	
Beneficiary Last Name		Beneficiary First Name		HICN	
Date of Service: From		Date of Service: To		Total Claim Billed Amount	
Billing Provider's Name:				Contact and Phone Number	
NPI:		PTAN:			
State Where Services Were Provided				Total Number of Pages (including cover sheet):	

Comments

Provider Name and Address/Fax

Print and Return Completed Form and Documentation to
Fax: 701-277-7852
Noridian
PO Box 6783
Fargo, ND 58108-6783

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