

Medicare will not process a beneficiary request for payment for diabetic test strips, Part B drugs, or for items paid for under the DMEPOS Competitive Bidding program.

Patient's Request for Medical Payment

IMPORTANT: Attach itemized bills from your doctor(s) or supplier(s) to this form.

MEDICAL INSURANCE BENEFITS UNDER SOCIAL SECURITY ACT

SEND ONLY THE COMPLETED FORM TO YOUR MEDICARE ADMINISTRATIVE CONTRACTOR – SEE PAGE 9 FOR LIST OF ADDRESSES.

IF YOU NEED HELP, CALL 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Type of Patient Request (see instructions on Page 8 for additional information, check one box only):

Influenza/Pneumococcal Vaccination

Part B (includes physician, laboratory, imaging services)

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Foreign Travel (including Canada or Mexico)

Shipboard Services

PLEASE TYPE OR PRINT INFORMATION

Section 1 - Information about You

Print your name as shown on your Medicare Card

First Name: Last Name: Middle Name:

Male Female

Date of Birth ____/____/____

Print your Health Insurance Claim Number exactly as it is shown on your Medicare Card

Your Mailing Address:

Street or P.O. Box – include apartment number:

City

State ZipCode

Check here if this is a new address
Day time phone number including Area Code

(__) ___ - ____

If you **DO NOT** want payment information from this claim released to your other insurer, check the following box

Section 2 - Information about Service(s) Furnished

FOR ALL CLAIMS INCLUDING Influenza and Pneumococcal Vaccinations

Enter the diagnosis and describe the illness or injury for which you received treatment.

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service,
- Place of service,
- Description of illness or injury,
- **Description of each surgical or medical service or supply furnished,**
- **Charge for each service,**
- **The doctor's or supplier's name and address,**
- **The provider or supplier's National Provider Identifier (NPI)**

Was the Condition related to:

Your employment?

Yes No

Treatment for chronic dialysis or kidney transplant?

Yes No

Accident

Yes No

If the answer is yes, Auto Other

ADDITIONAL INFORMATION FOR VACCINATION

Attach receipt from the physician/ provider that gave you the vaccination. The receipt should include:

Provider's name

Provider's Address

Date of Service

Charge for the Service

Section 3 - Information About Health Insurance Other than Medicare

Complete this section if you are:

Age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and covered by any other medical insurance other than Medicare

Are you employed and covered under an employee health plan Yes No

Is your spouse employed and are you covered under your spouse's employee health plan Yes No

Do you have any medical coverage other than Medicare, such as private insurance, MEDIGAP, employment related insurance, Medicaid, or the Veterans Administration Yes No

Name of other medical coverage:

Address of other medical coverage:

Street or P.O. Box

City

State

ZipCode

Policy number including Medicaid or Medical Assistance number:

Policy Holder's name: (Last, First, Middle)

Please add a copy of your primary insurer's Explanation of Benefits if Medicare is secondary.

Section 4 - Information about Your Physician or Eligible Practitioner

Name of physician or eligible practitioner (e.g.; Nurse Practitioner, Physician Assistant) who treated you:

First Name:

Last Name:

Middle Name:

National Provider Identifier (NPI), if known

Location of Service:

Street

City

State

ZipCode

Date of Service: Month

Day

Year

Did your physician, or other individual practitioner, refer you to a clinical laboratory, an independent diagnostic testing facility, a portable x-ray supplier, or any other supplier for additional test or services:

Yes If yes, complete section 5 and section 6

No If no, skip section 5 and complete section 6

FORM CMS-1490S (SC) (XX/XX) EF 09/2019

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Section 5 - Information about Your Supplier or Physician's Supplier

If you received medical services from a clinical laboratory, independent diagnostic testing facility, or a supplier complete the information below.

Name of Supplier:

National Provider Identifier (NPI), if known:

Location of Service:

Street of P.O. Box

City State ZipCode

Date of Service: Month Day Year

Section 6 -Signature

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

I authorize any holder of medical or other information about me to release it to the Centers for Medicare & Medicaid Services or its designated contractor or the Social Security Administration for this Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to me.

Signature of Patient

Date signed -----/-----/-----

All signatures must be original and signed in ink (blue ink preferred). Stamped, faxed or copied signatures will not be accepted.

If you are unable to sign, check the box: Then have a witness sign and include his/her address below.

If you are completing this form for another Medicare patient, you should write your name, sign and include your address. Also you should show your relationship to the patient and briefly explain why the patient cannot sign.

Name of witness: Last name First Name Middle Name

Signature of Witness

Date signed: -----/-----/-----

Relationship with the patient:

Reason why the patient cannot sign:

Send the completed form and supporting documentation to your Medicare contractor. For address of your Medicare Contractor, please see list starting on Page 11. If you still do not know the address of your Medicare contractor, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Do not mail your claim form to this address. Mailing a claim form to this address will result in the form and its attachments being returned to you.

DO NOT SEND THE FOLLOWING PAGES WITH THE FORM

Patient's Request for Medical Payment for the Flu Shot, Part B Services, including Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS), Foreign Travel (including Canada and Mexico) and Shipboard Services

Physicians and other suppliers, such as clinical laboratories and imaging service suppliers, and durable medical equipment suppliers, are required by law to submit a claim for Medicare covered services furnished to you, the Medicare beneficiary, within one year of the date of service.

To reduce your out-of-pocket expenses, Medicare beneficiaries should always obtain medical care from physicians and other suppliers who are enrolled in the Medicare program. If you submit a claim for covered services furnished by a physician or other supplier who is not enrolled with the Medicare program, your claim may be denied.

For a list of participating Medicare enrolled physicians in your area, please go to www.medicare.gov and select physician compare or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

To file a claim with Medicare, please complete all sections of this form, provide an itemized bill from your physician or supplier, attach any supporting medical information you feel is necessary, and explain in detail your reason for submitting the claim. For example, write a purpose statement notifying the Medicare contractor of your situation. Common situations include:

- your provider or supplier refused or is unable to file a claim for a Medicare-covered service
- your provider or supplier is not enrolled with Medicare

If a physician or supplier furnishes Medicare covered services to you and refuses to submit a claim on your behalf for those services, please call 1-800-MEDICARE (1-800-633-4227) in order to file a complaint with the Medicare contractor. TTY users should call 1-877-486-2048.

When you submit your own claim to Medicare, complete the entire form. If the claim form has incomplete or invalid information, the Medicare contractor will return the claim along with a letter to you clearly stating what information is missing or invalid.

If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.

See Page 6 for Collection and Use of Medicare Information

See Pages 7-8 for instructions about how to fill out the form and the supporting documentation needed

See pages 9-14 for information on where to mail this form.

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Read Before Submitting a Claim to Medicare
(Please return only the form and NOT the instruction)

General Instructions

- If you are submitting a claim for services from a doctor or eligible practitioner, then complete sections 1 – 4, sign and date the form.
- If you are submitting a claim for services from a clinical laboratory, independent diagnostic testing facility, or supplier of medical equipment, then complete all sections, sign and date the form.
- Send the completed claim form, your itemized bill, and any supporting documents to the appropriate Medicare contractor and explain in detail your reason for submitting the claim. For example, include a statement that notifies the Medicare contractor that your provider or supplier refused or is unable to file a claim for a Medicare-covered service and/or is not enrolled with Medicare.
- You should make copies of your claim submission for your records. Please allow at least 60 days for Medicare to receive and process your request. If you have any other questions, please feel free to call us at 1-800-MEDICARE (1-800-633-4227).

Seasonal Influenza and Pneumococcal Vaccination:

Medicare may pay for seasonal influenza and pneumococcal vaccinations. Medicare does not pay for the hepatitis B vaccines. Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer seasonal influenza vaccination must take assignment on the claim for the vaccine.

Part B Services:

In most situations, your physician, other practitioner or supplier will submit your claim to Medicare, if they do not, you can submit a claim.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies:

In most situations, your supplier of DMEPOS will submit your claim to Medicare, if they do not, you can submit a claim for an item or services furnished by this supplier.

Foreign Travel (including Canada and Mexico):

In most situations, Medicare will not pay for health care outside the United States (U.S.) and its territories. The term "outside the U.S." means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign hospital (a hospital outside the U.S.) in the following situations:

- If an emergency arose within the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- If you live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Shipboard Services:

Medicare may pay for medically necessary shipboard services if the services were provided while the ship was within United States (U.S.) waters. If you had medical services aboard a ship and the doctor's office is not in the U.S., then you can submit a claim to Medicare. If you had medical services aboard a ship and the doctor's office is located in the U.S., the doctor will submit the claim to Medicare.

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COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

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Do not mail your claim form to this address. Mailing a claim form to this address will result in the form and its attachments being returned to you.

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HOW TO FILL OUT THIS MEDICARE FORM

Medicare may pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Mail your completed claim form to the Medicare contractor responsible for processing your claim. If you need additional assistance, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

Check one of the following on top of the form: Seasonal Influenza and Pneumococcal Vaccination or Part B Services (includes physician, laboratory, imaging services) or Durable Medical Equipment, Prosthetics, Orthotics and Supplies or Foreign Travel (including Canada or Mexico) or Shipboard Services.

Section 1 – Information about you

Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Check the appropriate box for the patient's sex.

Print your Health Insurance Claim Number including the letter at the end

Furnish your mailing address and include your telephone number

Section 2- Information about services furnished

Enter the diagnosis and describe the illness or injury for which you received treatment.

Check the appropriate boxes

For Seasonal Influenza/Pneumococcal vaccination, attach receipt from the physician/provider that gave you the vaccination. The receipt should include:

Provider's Name, Provider's Address, Date of Service and Charge for the Service

Section 3 – Information about other Health Care Payers

Complete this Section if you are age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and if you have any medical coverage other than Medicare.

Be sure to provide the name of the other Medical Coverage

Policy number of the private insurance or MEDIGAP or Medicaid/Medical Assistance/VA or any other Medical Coverage you may have.

Address of the other Medical Coverage you may have

If the policy is not in your name, include the Policy Holder's name

Section 4 - Information about your Physician or Eligible Practitioner (e.g.; Nurse Practitioner, Physician Assistant, Dentist etc)

Enter the name of your physician or eligible practitioner

National Provider Identifier of your physician or the eligible practitioner, if known

Location of Service

Date of Service

Whether you were referred to a laboratory, independent diagnostic testing facility or a supplier

Section 5-Information about Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Portable X- Ray Supplier

Complete this section if you have received medical services from a clinical laboratory, independent diagnostic testing facility, portable x-ray supplier.

Include the name of the service provider

National Provider Identifier, if known

Location of Service and Date of Service

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Section 6- Signature and Date

Sign your name and date the form

If the Medicare beneficiary is not able to sign his/her name, follow the instructions on the form.

Attach the itemized bill and other supporting documentation

You must attach an itemized bill in order for Medicare to process this claim.

Each itemized bill MUST show all of the following information:

Date of each service

Place of each service

Doctor's Office Independent Laboratory Outpatient Hospital Nursing Home

Patient's Home Inpatient Hospital

Description of each surgical or medical service or supply furnished

Charge for each service

Doctor's or supplier's name and address

Many times a bill will show the names of several doctors or suppliers. It is very important the one who **treated you be identified**. Simply circle his/her name on the bill.

It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed section 2 of this form.

Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.

If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.

Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

Send the completed claim form and supporting documentation to the appropriate Medicare contractor for your claim (see list on page 11). If you need help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

FOR SEASONAL INFLUENZA AND PNEUMOCOCCAL VACCINATION, PART B SERVICES, FOREIGN TRAVEL AND SHIPBOARD SERVICES.

If you received a service in:	Return your form to:
Alabama	Cahaba Medicare Part B P.O. Box 6169 Indianapolis, IN 46206
Alaska	Noridian Healthcare Solutions, LLC P.O. Box 6703 Fargo, ND 58108-6703
American Samoa	Noridian Healthcare Solutions, LLC P.O. Box 6777 Fargo, ND 58108-6777
Arkansas	Novitas Solutions, Inc. P.O. Box 3098 Mechanicsburg, PA 17055-1816 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)
Arizona	Noridian Healthcare Solutions , LLC P.O. Box 6704 Fargo, ND 58108-6704
California Northern (For Part B)	Noridian Healthcare Solutions P.O. Box 6774 Fargo, ND 58108-6774
California Southern (For Part B)	Noridian Healthcare Solutions, LLC P.O. Box 6775 Fargo, ND 58108-6775
Colorado	Novitas Solutions P.O. Box 3107 Mechanicsburg, PA 17055-1823 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050
Connecticut	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Delaware	Novitas Solutions P.O. Box 3397 Mechanicsburg, PA 17055-1842

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District of Columbia (Washington DC)	<p>Novitas Solutions, Inc. P.O. Box 3396 Mechanicsburg, PA 17055-1841</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050</p>
Florida	<p>First Coast Service Options, Inc. P.O. Box 2525 Jacksonville, FL 32231-0019</p>
Georgia	<p>Cahaba Medicare Part B P.O. Box 6169 Indianapolis, IN 46206</p>
Guam	<p>Noridian Healthcare Solutions, LLC P.O. Box 6777 Fargo, ND 58108-6777</p>
Hawaii	<p>Noridian Healthcare Solutions, LLC P.O. Box 6777 Fargo, ND 58108-6777</p>
Idaho	<p>Noridian Healthcare Solutions, LLC P.O. Box 6701 Fargo, ND 58108-6701</p>
Illinois	<p>National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475</p>
Indiana	<p>Wisconsin Physicians Service P.O. Box 8940 Madison, WI 53708-8940</p>
Iowa	<p>Wisconsin Physicians Service P.O. Box 8550 Madison, WI 53708-8550</p>
Kansas	<p>Wisconsin Physicians Service P.O. Box 7238 Madison, WI 53707-7238</p>
Kentucky	<p>CGS Administrators, LLC P.O. Box 20019 Nashville, TN 37202</p>
Louisiana	<p>Novitas Solutions, Inc. P.O. Box 3097 Mechanicsburg, PA 17055-1815</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050</p>

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Maine	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Maryland	Novitas Solutions, Inc. P.O. Box 3398 Mechanicsburg, PA 17055-1843 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)
Massachusetts	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Michigan	Wisconsin Physicians Service P.O. Box 8987 Madison, WI 53708-8987
Minnesota	National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475
Mississippi	Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834 (Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)
Missouri	Wisconsin Physicians Service P.O. Box 14260 Madison, WI 53708-0260
Montana	Noridian Healthcare Solutions, LLC P.O. Box 6735 Fargo, ND 58108-6735
Nebraska	Wisconsin Physicians Service P.O. Box 8667 Madison, WI 53708-8667
Nevada	Noridian Healthcare Solutions, LLC P.O. Box 6776 Fargo, ND 58108-6776
New Hampshire	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178

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New Jersey	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address:</p> <p>Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)</p>
New Mexico	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address:</p> <p>Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)</p>
New York	<p>National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178</p>
North Carolina	<p>Palmetto GBA, LLC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190</p>
North Dakota	<p>Noridian Healthcare Solutions, LLC P.O. Box 6706 Fargo, ND 58108-6706</p>
Northern Mariana Islands	<p>Noridian Healthcare Solutions P.O. Box 6777 Fargo, ND 58108-6777</p>
Ohio	<p>CGS Administrators, LLC P.O. Box 20019 Nashville, TN 37202</p>
Oklahoma	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address:</p> <p>Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)</p>
Oregon	<p>Noridian Healthcare Solutions P.O. Box 6702 Fargo, ND 58108-6702</p>

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Pennsylvania	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address:</p> <p>Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)</p>
Puerto Rico	<p>First Coast Service Options, Inc. P. O. Box 45036 Jacksonville, Florida 32232-5036</p>
Rhode Island	<p>National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178</p>
South Carolina	<p>Palmetto GBA Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190</p>
South Dakota	<p>Noridian Healthcare Solutions, LLC P.O. Box 6707 Fargo, ND 58108-6707</p>
Tennessee	<p>Cahaba Medicare Part B P.O. Box 6169 Indianapolis, IN</p>
Texas	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address:</p> <p>Novitas Solutions, Inc. Attention: JL Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050)</p>
Utah	<p>Noridian Healthcare Solutions P.O. Box 6725 Fargo, ND 58108-6725</p>
Vermont	<p>National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178</p>
Virginia	<p>Palmetto GBA Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190</p>
Virgin Islands	<p>First Coast Service Options, Inc. P. O. Box 45098 Jacksonville, Florida 32232-5098</p>

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Washington	Noridian Healthcare Solutions P.O. Box 6700 Fargo, ND 58108-6700
West Virginia	Palmetto GBA, LLC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
Wisconsin	National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475
Wyoming	Noridian Healthcare Solutions P.O. Box 6708 Fargo, ND 58108-6708

FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS) ONLY

If you live in:	Return your form and Supporting Documentation to:
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian JA DME P.O. Box 6727 Fargo, ND 58108-6727
Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin Indianapolis, IN 46207-7027	CGS Administrators, LLC P.O. Box 20010 Nashville, TN 37202-001
Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia	CGS Administrators, LLC P.O. Box 20010 Nashville, TN 37202-001
Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian JD DME P.O. Box 6727 Fargo, ND 58108-6727

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