

CLAIM IDENTIFIER

Company Name _____
GROUP # _____

Employee Name

Identification #

Patient's Name

Relationship to Employee

ATTACH ITEMIZED BILLS & MAIL DIRECTLY TO:

Noridian Benefit Plan Administrators

P. O. Box 2339
Fargo, ND 58108-2339

Providers (701) 237-4787
Employees (800) 554-3951