Nebraska Out-of-Network Emergency Appeal Form

*For **emergency** services supplied by providers **not** in the Medica network.*

Provider/Facility Information	
Provider/Facility name:	Date of request:
Provider address:	Provider tax identification number (TIN):
Provider contact name:	Provider contact telephone number:
Name/address of the facility:	Performing provider's telephone number:
Name/address of referring provider (if applicable):	Referring provider's telephone number:

Patient Information	
Medica member name:	
Date of birth:	Medica group & ID number:

Payment Information	
Date of service (DOS):	Billed amount:
Claim number:	Payment received:
Authorization number (if applicable):	
Reason for payment appeal:	

After completing this form, return it to Medica at the appropriate mailing address below along with the original payment. Upon receipt of the returned payment and form, the provider and Medica will have 30 days to negotiate a settlement.

For members with payer ID 12422:	**For members with payer ID 71890, 53589, or 88090:**
Medica PO Box 21051 Eagan, MN 55121-0051	Medica PO Box 211435 Eagan, MN 55121-0051