Behavioral Health (BH)/Substance Use Disorder (SU) Prior Authorization Request form

Complete this form if the members ID card includes one of the following group numbers: A0021, A0022, A0041, A0042
Fax this form to 952-992-2396

Medica requires that providers obtain prior authorization before rendering any of the care listed below under "Services Requested:" Written documentation from the medical record, supporting the services must be submitted for all requests. Failure to do so may result in a delay of the decision.

Patient Information	Today's Date:
Patient Name:	DOB Month/Day /Year:
Patient Phone Number (Area code + Number):	Patient's Medica ID Number Group: Policy:
Service/Procedure Requested	
☐ EXPEDITED REQUEST Medical reason for expedited review:	
Services Requested:	
☐ BH/SU Residential ☐ Out of Network Elective Services ☐ Elective Inpatient BH/SU Hospitalization	
Prior Authorization Request Information	
Proposed date(s) of service (estimated length of stay):	CPT codes:
Number of visits or days:	Relevant ICD-10 code(s):
Ordering Provider Information	**Performing Provider Information**
Provider name & address:	Provider name & address:
Telephone & fax number:	Telephone & fax number:
National Provider Identification (NPI): Federal Tax ID (TIN):	National Provider Identification (NPI): Federal TAX ID (TIN):
Provider contact name & number:	

Submission of this completed form certifies that the information is true and accurate. All fields arerequired for processing your request. For information on submitting this form and/or any other information, please go to: https://partner.medica.com/providers/contact-medica

If any items on the Medica Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim orclaims will be denied as provider liability.