Prior Authorization Request Form

Before submitting this request, please verify that the code(s) you are requesting require prior authorization (PA)
Medica's PA list can be found on Medica.com or click here: PA List

Medica requires that providers obtain prior authorization before rendering services. If any items on the Medica Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability. The provider will have 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity.

Patient Information	
Today's Date	Patient DOB Month / Day / Year
Patient Name	Patient's Medica ID Number Group Policy
Patient Phone Number (Area Code + Number)	
Prior Authorization Information	
Facility Name	Facility Address
Facility Telephone Number	City State Zip
Facility Fax Number	Facility Tax ID Number (TIN)
Proposed Date of Service	
Service/Procedure Requested	Check One: ☐ Inpatient ☐ Outpatient
Diagnosis/ICD-10 Code(s) **must be a billable code	
CPT Code(s)	
Please note that written documentation from the medical record, including photos in some cases, supporting the procedure must be submitted for all requests. Clinical/Photos included? ☐ Yes ☐ No	
Ordering Provider Information	
Provider Name	Clinic Name
Federal Tax ID	Address
NPI Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number

Please note that written documentation from the medical record, including photos in some cases, supporting the procedure must be submitted for all requests. *Failure to do so may result in a delay of the decision*. Unless this request is for genetic related testing, do not provide any genetic information. Genetic information includes any family medical history or information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the patient may be at risk.

Submission of this completed form certifies that the information is true and accurate. All fields are required for processing your request. Submit form by:

- For group numbers that begin with IFB or C: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- For group numbers that begin with A **(excluding A0061 & A00500):** Fax to 952-992-2396 or E-Mail to hpshealthmanagement@medica.com
- For all other group numbers **(including A0061 & A00500):** Fax to 952-992-3556 or E-Mail to caremanagement@medica.com
- U.S. Mail to Medica, Utilization Management and Clinical Appeals, PO Box 9310, CP440, Minneapolis, MN 55440

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