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

**Fax this form to 952-992-1428**

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.

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

| Patient Information | Today's Date: |
|---|---|
| Patient Name: | DOB Month/Day/Year: |
| Patient Phone Number (Area code + Number): | Patient's ID Number Group:<br><br>Policy: |
| **Service/Procedure Requested** | |
| ☐ EXPEDITED REQUEST Medical reason for expedited review: | |
| **Services Requested:** | |
| ☐ BH/SU Residential<br>☐ Out of Network Elective Services<br>☐ 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 Number:<br><br>Fax Number: | Telephone Number:<br><br>Fax number: |
| National Provider Identification (NPI):<br><br>Federal Tax ID (TIN): | National Provider Identification (NPI):<br><br>Federal TAX ID (TIN): |
| Provider contact name: | |

**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.**