Medica.

Prior Authorization Request Form

Before submitting this request, please verify that the code(s) you are requesting require prior authorization (PA)

Medica Central Health Plan requires that providers obtain prior authorization before rendering services. If any items on the Medica Central Health Plan Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims may be denied as provider liability.

Please note that written documentation from the medical record, including photos in some cases, supporting the procedure must be submitted for all requests unless the Health Plan has access to the member's Electronic Medical Record (EMR). 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 DOB Month/Day/Year
Patient Name	Patient Phone Number (Area Code + Number)
Patient's ID Number Group:	Policy:
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	Check One: ☐ Inpatient ☐ Outpatient ☐ DME
Service/Procedure Requested	
Number of Visits or Days	
Diagnosis/ICD-10 Code(s) **must be a billable code	
CPT/HCPCS 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

Submit form by utilizing the options below:

- For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440

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