Prior Authorization Update Form

Please use this form for updates to existing approved clinical prior authorizations previously submitted via fax or electronic submission on the Availity Essentials Provider Portal.

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	
Authorization Number Requiring Update	
Requested Update (please check all that apply): □CPT/HCPCS Code(s) □Date(s) of Service □Servicing Provider(s)	 □Units/Visits □Other
Please provide details of requested update:	

Requesting 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