Wheelchair and Accessory Prior Authorization Request Form

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.

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

Member Information	
Today's Date	Member DOB Month/Day/Year
Member Name	Member Phone Number (Area Code + Number)
Member ID Number Group:	Policy:
Prior Authorization Information	
DME Provider Name	DME Provider Address
DME Provider Telephone Number	City State Zip
DME Provider Fax Number	DME Provider Tax ID Number (TIN)
Proposed Date of Service	
DME Service Requested	Place of Service Code
Diagnosis/ICD-10 Code(s) **must be a billable code	
CPT/HCPCS Code(s)	
Relevant Inpatient Surgical ICD-10 Code(s)	
Ordering Provider Information	
Provider Name	Clinic Name
NPI Number	Address
Federal Tax ID Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number

Wheelchair and Accessory Prior Authorization Request Form
Purchase/Replacement/Repair Information

Please note that written documentation from the medical record, including support for the DME service, must be submitted for all requests. ***Failure to do so may result in a delay of the decision.***

MEMBER NAME: _____
Medica HEALTH MEMBER ID: _____

☐ PURCHASE OF WHEELCHAIR OR ACCESSORY
ANTICIPATED DATE OF PURCHASE: _____

☐ REPLACEMENT OF WHEELCHAIR OR ACCESSORY
DATE OF ORIGINAL PURCHASE OR DELIVERY: _____

ORIGINAL PAYER: _____

REASON FOR REPLACEMENT: _____

☐ REPAIR OF WHEELCHAIR OR ACCESSORY_____
MAKE/MODEL/MANUFACTURER OF WHEELCHAIR OR ACCESSORY: _____
☐ *You may provide/attach the manufacturer's specification sheet for this information*

ORIGINAL PAYER: _____

COST OF WHEELCHAIR OR ACCESSORY REPAIR: _____

COST OF WHEELCHAIR OR ACCESSORY REPLACEMENT: _____

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