Clear Form

Medica.

Medica Behavioral Health Mental Health Retrospective Review Request Form

Please Note: As of 1/1/2024 Medica has removed prior authorization requirements on many behavioral health services. For a full list please use this link: Medica Prior Authorization (PA) and Notification Requirements

- Only use this form for Mental Health Retrospective Review Requests (**services that have taken place in the past**).
- Substance Abuse Retrospective Review Form can be found @ www.providerexpress.com
- Psychological Testing requests for non-participating providers can be found @ www.providerexpress.com
- Please call us (800-848-8327) and we will be happy to assist you with this process.

Member Information:

Member Name: _____

DOB: _____ Medica ID #: _____

Member Address: _____

Provider Information:

Name of Provider/Facility: _____ Fax#: _____

Tax ID number: _____

Provider Network Status at Time of Service: (Check One) ☐ Participating ☐ Non-Participating

-or- Provider Address where services were rendered: _____

Contact Name: _____ Phone Number: _____

Mental Health Requested Level of Care/Services: (Check ONLY One of the Following Below)

Check	Service	Date of Service prior to 1/1/2024 All Plan Types	Date of Services after 1/1/2024 All Plan types unless otherwise specified below
☐	Inpatient & Residential	Submit the Retro Request Form with clinical documentation	Submit the Retro Request Form with clinical documentation
☐	Partial Hospitalization (PHP)	Submit the Retro Request Form with clinical documentation	Product specific directions: Medicare or Medicaid DSNP Plans -Submit Retro Request Form All Other Plan Types- No auth required. Submit claim for the service.
☐	Eating Disorder IOP	Submit the Retro Request Form with clinical documentation	No auth required for all plan types. Submit claim for the service.
☐	TMS & ABA	Submit the Retro Request Form with clinical documentation	No auth required for all plan types. Submit claim for the service.
☐	EIDBI	Submit the Retro Request Form with clinical documentation	Medicaid only requires service agreement/authorization. Please submit the Retro Request Form with clinical documentation.

First Date of Service(s) Requested: _____ Last Date/Discharge Date of Service(s): _____

Number of Days/Sessions Request: _____ Procedure/CPT/HCPC Codes: _____

Please mail or fax this fully completed form to: Medica Behavioral Health · Attn: UBH Retro Review · P. O Box 1459 · MN101-E700 ·Minneapolis, MN 55440-1459 ·Fax #1/855-454-8155