Clear Form

Medica.

Substance Use Disorder Medica Behavioral 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 Substance Abuse Retrospective Review Requests (**services that have taken place in the past**).
- Substance Abuse Retrospective Review Form 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: _____

SUD Requested Level of Care/Services:

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
SUD Inpatient & Residential Withdrawal Management & Detox	Submit the Retro Request Form with clinical documentation	Submit the Retro Request Form with clinical documentation
SUD Partial Hospitalization (PHP)	Submit the Retro Request Form with clinical documentation	Product specific directions: Medicaid DSNP plan- Submit Retro Request Form if the plan Other Plan Types- No auth required. Submit claim for the service.
SUD IOP /SUD OP	Submit the Retro Request Form. Commercial & Medicaid ONLY	SUD IOP-No auth required for all plan types. Submit claim for the service. SUD OP- Commercial Plans- DOS after 6/15/2024 no auth required. Submit claims for the service. Medicaid Plans- DOS after 9/1/2024 no auth required. Submit claims for the service.

Section A: Substance Use Disorder Requested Level of Care/Services: (Check ONLY one of the following below)

☐ Inpatient or Residential ☐ Detoxification ☐ PHP ☐ IOP

Admission Date(s) of Service Requested: _____

Discharge Date of Service Requested: _____

Number of Days/Sessions Requested: _____

MN Medicaid ONLY Inpatient/Residential / Detoxification Room and Board billing:
Only fill out Section below if Room and Board services will be billed to Medica.

Track: (Choose One)	For MN Program Use **Program Specifics/Modifiers**:
☐ Adolescent Residential Services ☐ Adult Residential Services	☐ Co-Occurring Services ☐ Recipients with Children ☐ Special Populations ☐ Medical Services
Intensity Level (for MN programs) ☐ High (>30 hours/weekly) ☐ Medium (15-29hours/weekly) ☐ Low (5-14 hours/weekly)	
☐ Detoxification	☐ Community Based ☐ Hospital Based

Section B: Substance Abuse Outpatient/IOP Treatment: Administrative Authorization Only, clinical documentation not needed. Check only ONE of the following below to indicate if treatment Services provided are billed Per Diem or Hourly.

☐ Per Diem: Total # of Days being requested: _____
First Date(s) of Service Requested: _____End Date(s) of Service Requested: _____
Number of Days/Sessions Requested: _____ CPT or HCPCS Codes for Outpatient Services: _____

-OR-

☐ Total # of Treatment Hours being requested: _____
Date(s) of Service Requested: _____
Number of Group Hours: _____Number of Individual Hours: _____
CPT or HCPCS Codes for Outpatient Services: _____

Track: (Choose One)	For MN program use **Program Specifics/Modifiers**: (Check all that apply)
☐ Adolescent ☐ Adult ☐ Geriatric	☐ Co-Occurring Services ☐ Recipients with Children ☐ Special Populations ☐ Medical Services
☐ Methadone	☐ Methadone ☐ Other Medication

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