Prior authorization

Individual + family plans

Getting approval for your service

Before you can get care for certain services, you may need approval from us[1]. Without approval, your plan may not cover them[2]. This is known as prior authorization. It helps us make sure the service your doctor recommends is appropriate and necessary for treating your condition based on recognized clinical standards of care. It also helps us to control health care costs by reducing duplicate or unneeded treatments.

Services that require prior authorization

You may need prior authorization for these services:

- Certain prescription drugs
- Home health care
- Medical supplies and durable medical equipment
- Bone marrow transplants
- Referrals to certain types of network providers
- Referrals to providers who aren't in your network

This isn't a complete list. For the complete list, call Member Services at the number on the back of your Medica ID card.

How to request prior authorization or a coverage exception

Determine the scenario below that best describes the services or supplies you need. Then follow the steps below it.

For covered services and supplies received from a network provider
It's your provider's responsibility to make the request, if needed[2]. In most cases, if they don't submit a request, and we deny your claim, they'll be responsible for the cost.

For covered prescription drugs received from a network provider
It's your provider's responsibility to make the request before you fill your prescription, if needed[2]. If they don't submit a request, we may deny your claim. This may result in you paying the full cost for the drug or a delay in receiving your prescription.

For non-covered prescription drugs or prior authorization, step therapy, and formulary exceptions from a network provider
If you or your provider requests that you get a prescription drug that's not on your drug list, or you or your provider request an exception to prior authorization, step therapy, or formulary requirements, you'll need to request a prescription drug exception. To learn how to submit a request, see "Requesting a Prescription Drug Exception."

For services and supplies received from an out-of-network provider
You or someone on your behalf must make the request. Call Member Services at the number on the back of your Medica ID card. If you don't get approval ahead of time, we may deny your claim(s). This may result in a large bill for you, as many of our plans don't have out-of-network benefits.

For an overview of out-of-network costs and how they're calculated, read our "**Out-of-Network**" tip sheet found on your secure member site.

Medica

Approving prior authorization requests

The approval process and timeline varies based on the state where you purchased your health plan. Find your state below for our policy.

Arizona
We'll review your request and get you an answer within 14 calendar days upon receipt of complete information.

Illinois
We'll review your request and provide an answer:

- Within 72 hours for standard exception requests
- Within 24 hours for urgent step therapy exception requests

Iowa
We'll review your request and provide an answer:

- Within 10 business days[3] from the date we received it for medical services and supplies requests
- Within 5 calendar days[3] upon receipt of complete information for prescription drug requests

Kansas and Oklahoma
We'll review your request and get you an answer within 10 business days[3] upon receipt of complete information.

Minnesota
We'll review your electronic request and get you an answer within 5 business days upon receipt of complete information.

Missouri
We'll review your request and provide an answer within 36 hours (which includes one working day) upon receipt of complete information.

Nebraska and North Dakota
We'll review your request and get you an answer within 15 calendar days[3] upon receipt of complete information.

Wisconsin
We'll review your request and get you an answer:

- Within 10 business days[3] upon receipt of complete information.
- Within 5 business days[3] from the date we received it for an experimental procedure request

[1] Behavioral health services must be approved by Optum Health, Medica's behavioral health network administrator.

[2] Receiving prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon many factors, including your eligibility and terms and conditions of the policy on the date you received services.

[3] If your attending provider believes that an expedited review is warranted or Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, we will inform both you and your provider of the decision as soon as possible but not later than 72 hours from the time of the initial request.

Have questions? We can help.

Call Member Services at the number on the back of your Medica ID card.

Medica

Medica complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

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