MEMBER TIPS

PRIOR AUTHORIZATION & MEDICAL NECESSITY

ENROLLED IN INDIVIDUAL & FAMILY PLANS

GETTING APPROVAL FOR YOUR SERVICE

Before receiving care for certain services, you may need approval from Medica. Without approval, your plan may not cover them[1]. This is known as **prior authorization**. It helps us confirm medical necessity — meaning that the service recommended by your doctor is appropriate and necessary for treating your condition based on recognized clinical standards of care. This helps us to control health care costs by reducing duplicate or unnecessary treatment.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

You may need prior authorization from Medica for the following services:

- Certain prescription drugs
- Home health care
- Medical supplies and durable medical equipment
- Organ and bone marrow transplant
- Referrals to certain types of network providers
- Referrals to providers who are not in your network

This is not a complete list. For a complete list of services, visit **medica.com/PriorAuthorization**.

HOW TO REQUEST PRIOR AUTHORIZATION

To help you determine if you're responsible for requesting prior authorization, determine the scenario below that best describes the services or supplies you need. Then follow the steps below it.

For Services and Supplies Received From a Network Provider

You don't need to do anything. It's your provider's responsibility to make the request. In most cases, if they don't submit a request, and we deny your claim, they are responsible for the cost.

For Prescription Drugs Received From a Network Provider

You don't need to do anything. It's your provider's responsibility to make the request before you fill your prescription[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.

For Services and Supplies Received From an Out-of-Network Provider

You or someone on your behalf must make the request. Call Medica at the number on the back of your Medica ID card. If you don't receive approval ahead of time, we may deny your claim(s). Or, pay it at out-of-network benefits. This may result in a large bill for you.

For an overview of out-of-network costs and how they're calculated, read our "Out-of-Network" tip sheet found on **medica.com/ifbmembertips**.

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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.

Iowa

We will review your request and provide an answer:

- Within 10 business days[3] from the date it was received for medical services and supplies requests
- Within 5 calendar days[3] from the date it was received for prescription drug requests

Kansas, Minnesota and Oklahoma

We will review your request and provide an answer within 10 business days[3] from the date it was received

Missouri

We will review your request and provide an answer within 36 hours[4] (which includes one working day) from the date all information needed was received.

Nebraska and North Dakota

We will review your request and provide an answer within 15 calendar days[3] from the date it was received for medical services and supplies requests

Wisconsin

We will review your request and provide an answer:

- Within 10 business days[3] from the date it was received for medical services and supplies requests
- Within 5 business days[3] from the date it was received for an experimental procedure request

[1]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.

[2]If your provider is requesting that you receive a prescription drug that is not on your drug list, you'll need to request a prescription drug exception. To learn how to submit a request, read our "Requesting a Prescription Drug Exception" tip sheet found on **medica.com/ifbmembertips**.

[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.

[4]Medica will notify your provider by phone or electronically within 24 hours of making a decision. If approved, we'll notify you and your provider via written or electronic confirmation within two working days of determination. If denied, within one working day of making the determination.

Have a question?

Call Customer Service at the number on the back of your Medica ID card.

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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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