Missouri Out-of-Network Emergency Appeal Form

*For **emergency** services supplied by providers **not** in the Medica provider network. This form is **only** applicable for services performed at an in-network facility by an out-of-network provider.*

Note: Health care professionals have 60 days from the initial claim paid date to make a request to negotiate.

Provider Information	
Provider name:	Date of request:
Provider address:	Provider tax identification number (TIN):
Provider contact name:	Provider contact telephone number:
Name/address of the network facility:	Performing provider's telephone number:
Name/address of referring provider (if applicable):	Referring provider's telephone number:

Patient Information	
Medica member name:	
Date of birth:	Medica group & ID number:

Payment Information	
Date of service (DOS):	Billed amount:
Claim number:	Payment received:
Authorization number (if applicable):	
Reason for payment appeal:	

After completing this form, return it to Medica by fax at 952-992-1427 or by U.S. mail at the following address. Please allow up to 30 calendar days for a response.

Medica
PO Box 21051
Eagan, MN 55121-0051

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