Pre-Service Payment Consent Form

This form is only for Medica members in employer-based health plans and individual and family health plans.

Member Name: _______________________________________________________

Medica Member ID Number: _____________________________________________

Provider Name: _______________________________________________________

National Provider Identifier (NPI) Number: _________________________________

Date(s) of Service: _____________________________________________________

Description of specific service(s) and reason service is not a covered benefit:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I understand that the services described above may not be covered by Medica. By signing this form, I know that I may have to pay for these services if Medica does not cover them. I also understand that I have the right to appeal a coverage decision that Medica makes if I disagree with it.

Member Signature: ___________________________________________ Date: __________________

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