MEDICA®

Out-of-Network RAPL Payment Appeal Form

*For radiology, anesthesia, pathology & laboratory (RAPL) providers **not** in the Medica provider network.*

RAPL PROVIDER'S INFORMATION	
RAPL Provider Name:	Today's Date:
RAPL Provider Address:	RAPL Provider Tax Identification Number (TIN):
RAPL Provider Contact Name:	RAPL Provider Contact Telephone Number:

Service provided (select one):

- ☐ Anesthesia
- ☐ Laboratory
- ☐ Pathology
- ☐ Radiology

PERFORMING/REFERRING PROVIDER INFORMATION	
Date of Service (DOS):	
Name/address of site of service (hospital or ACS):	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	
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 952-992-8667 or by U.S. mail at the following address. Please allow up to 30 calendar days for a response.

Medica Provider Services - RAPL Payment Appeal
Mail Route CP532
PO Box 9310
Minneapolis, MN 55440-9310