



Prior Authorization Request Form for Post-Acute Inpatient Admission (SNF, LTACH, Acute Rehab)

Medica requires that providers obtain prior authorization before rendering services. If any items on the Medica Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability. The provider will have 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity.

| Patient Information | |
|---|--|
| Today's Date | Patient DOB Month / Day / Year |
| Patient Name | Patient's Medica ID Number Group Policy |
| Patient Phone Number (Area Code + Number) | |
| Prior Authorization Information | |
| Facility Name | Facility Address |
| Admissions Contact/Telephone Number | City State Zip |
| Facility Fax Number | Facility Tax ID Number (TIN) |
| UR Contact Name/Phone Number for Clinical Updates | |
| Service Requested Check One: <input type="checkbox"/> SNF <input type="checkbox"/> LTACH <input type="checkbox"/> Acute Rehab | Inpatient Hospital Stay Dates: |
| Diagnosis/ICD-10 Code(s) **must be a billable code | |
| Proposed Admission Date | |
| <i>Please include clinical information for review: History & Physical (H&P), Orders to admit, PT/OT Evaluation</i> | |
| Ordering Provider Information | |
| Provider Name | Clinic Name |
| Federal Tax ID | Address |
| NPI Number | City State Zip |
| Telephone Number | Fax Number |

Please note that written documentation from the medical record supporting the stay must be submitted for all requests. *Failure to do so may result in a delay of the decision.* Unless this request is for genetic related testing, do not provide any genetic information. Genetic information includes any family medical history or information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the patient may be at risk.

Submission of this completed form certifies that the information is true and accurate. All fields are required for processing your request. Submit form by:

- Fax: 952-992-1428 or email postacute@medica.com
- U.S. Mail to Medica, Utilization Management and Clinical Appeals, PO Box 9310, CP440, Minneapolis, MN 55440