Out-of-Network Prior Authorization Request Form

Prevea360 requires that providers obtain prior authorization before rendering services. If any items on the Prevea360 Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims may be denied as provider liability.

Please note that written documentation from the medical record, including photos in some cases, supporting the procedure must be submitted for all requests unless the Health Plan has access to the member's Electronic Medical Record (EMR). Failure to do so may result in a delay of the decision.

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

Patient Information	
Today's Date	Patient DOB Month/Day/Year
Patient Name	Patient Phone Number (Area Code + Number)
Patient's ID Number Group:	Policy:
Ordering Provider Information	
Provider Name	Clinic Name
NPI Number	Address
Federal Tax ID Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number
Out-of-Network Provider Information	
Provider Name & Specialty	Clinic Name
NPI Number	Address
Federal Tax ID Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number
Facility Information (if applicable)	
Facility Name	Telephone Number Fax Number
NPI Number	Address
Federal Tax ID Number	City State Zip

Prior Authorization Information	
CPT Code(s)/HCPCS Code(s)	Care Level: ☐ 1. Consult in the office ☐ 2. Consult & Diagnose ☐ 3. Consult, Diagnose & Treat
Diagnosis/ICD-10 Code(s) **must be a billable code	
This referral request is valid for a maximum of visits from through	
Have you attempted to find an in-network Prevea360 Health Plan provider? ☐ Yes ☐ No	
Has the patient seen this out-of-network provider in the past? ☐ Yes ☐ No If so, when was the last visit? / (month/year)	
Summary of in-network specialists this patient has seen related to above diagnosis:	
Explain why the requested services can only be provided by this out-of-network provider.	

Submit form by utilizing the options below:

• For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
• U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440