Retrospective Review Request Form

Medica Behavioral Health – MN CAC Specific

Attach all clinical information and documentation that supports the need for the requested level of care/services.

- Only use this form for Retrospective Review Requests (services that have taken place in the past).
- Requests for Psychological Testing must be submitted on the Medica Psychological Testing Form along with this Retrospective Review Request Form.
- For participating providers where services were rendered within the last six months and the request is for 10 or less outpatient sessions (for CPT codes 90837 and 90838), you can call directly to MBH Intake (800-848-8327) for an authorization rather than completing this form.
- Complete the form in its entirety.
- Please call us (800-848-8327) and we will be happy to assist you with this process.

Member Information:

Member Name: _____

DOB: _____ Medica ID #: _____

Member Address: _____

Provider Information: Name of Provider/Facility: _____

Provider Network Status at Time of Service: (Check One) ☐ Participating ☐ Non-Participating

-or- Provider Address where services were rendered: _____

Provider Phone #: _____ Contact Name: _____

Mental Health Requested Level of Care/Services: (Check ONLY One of the Following Below)

*Reminder: Requests for Psychological Testing, DBT, ACT or ICBS, MUST be submitted on their separate respective forms in addition to the member and provider information filled out above.

☐ Inpatient or Residential ☐ Outpatient

☐ Partial

☐ Intensive Outpatient

☐ Other (provide narrative description of services): _____

First Date of Service(s) Requested: _____

End Date of Service(s) Requested: _____

Number of Days/Sessions Requested: _____

CPT or HCPCS Codes for Outpatient Services: _____

Substance Abuse Requested Level of Care/Services:

*Reminder: If a member is staying overnight at your facility AND room & board fee will be billed to Medica, please stop here and use the "Substance Abuse Residential/Programs with Lodging Authorization Request" and submit in addition to member and provider information filled out above.

Substance Abuse Outpatient Treatment: (Check ONLY One of the Following Below to indicate if Treatment Services provided are billed Per Diem or Hourly)

☐ Per Diem Total # of Days being requested: _____

First Date(s) of Service Requested: _____

End Date(s) of Service Requested: _____

Number of Days/Sessions Requested: _____

CPT or HCPCS Codes for Outpatient Services: _____

-OR-

☐ Hours: Total # of Treatment Hours being requested: _____

Date(s) of Service Requested: _____

Number of Group Hours: _____ Number of Individual Hours: _____

CPT or HCPCS Codes for Outpatient Services: _____

Track that is being requested: (Choose one):	**Program Specifics/Modifers (Check all that apply):**
☐ Adolescent Outpatient Adult Outpatient	☐ Co-Occurring Services Recipients with Children Special Populations Medical Services
☐ Medication Assisted Therapy Medication Assisted Therapy PLUS Services	Methadone Other Medication: _____

Please mail or fax this fully completed form to:

Medica Behavioral Health
Attn: UBH Retro Review P.O.
Box 1459 MN103-0500
Minneapolis, MN 55440-1459 OR

Fax to: 1/855-454-8155