Methadone Maintenance Treatment (MMT)/ Opioid Replacement Therapy (ORT) Program Initial/Annual Assessment:
Medica Behavioral Health

Date:_____ **Medica Alt ID/PMI #:** _____

Member Name:_____ **DOB:** _____

Current Member Address: _____

_____

_____

Program/Agency Name and Location (City): _____

Assessment* completed on (Date): _____
Type of Assessment: (Check One)
☐Initial (at the start of MMT/ORT services)
☐Annual (for members/clients continuing to receive MMT/ORT services)

Contact Person:_____**Phone Number:** _____

*Comprehensive assessment to be completed and forwarded to Medica Behavioral Health at the onset of MMT/ORT services **and** on an annual basis while receiving services

Please send a copy of the completed assessment along with this cover sheet to Medica Behavioral Health via:

Fax: 1/855-454-8155

-OR-

Mail: Medica Behavioral Health
PO Box 1459
MR: MN103-0500
Minneapolis, MN 55440-1459

Additional information and/or requested documents can be faxed to: 1/855-454-8155
or Mailed to: MN-CAC; P0 Box 1459; MR: MN103-0500; MPLS, MN 55440-1459
Optum manages the Medica Behavioral Health program

For Internal Use Only:
☐Location
☐Clinical