

Substance Abuse Retrospective Review Request Form

Medica Behavioral Health – MN CAC Specific Form

Information and Instructions:

- **Only use this form for Substance Abuse retrospective review requests (services that have taken place in the past).** Please call (800-848-8327) if assistance is needed with this process.

Also, when using this form please...

- Complete the form in its entirety, and
- Attach all clinical information and documentation that supports the need for the requested level of care/services.

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 -or- Non-Participating

Provider Address where services were rendered: _____

Provider Phone #: _____ Contact Name: _____

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

Inpatient or Residential Detoxification Intensive Outpatient Outpatient

Other (provide narrative description of services): _____

Section A: Inpatient / Residential / Lodging / Detoxification: Only fill out Section “A” if Room and Board services will be billed to Medica.

Track: (Choose One)	For MN Program Use Program Specifics/Modifiers:
<input type="checkbox"/> Adolescent Residential Services	<input type="checkbox"/> Co-Occurring Services
<input type="checkbox"/> Adult Residential Services Intensity Level (for MN programs) <input type="checkbox"/> High (> 30 hours Tx/month) <input type="checkbox"/> Medium (15-29 hours/month) <input type="checkbox"/> Low (5-14 hours/month)	<input type="checkbox"/> Recipients with Children <input type="checkbox"/> Special Populations <input type="checkbox"/> Medical Services
<input type="checkbox"/> Detoxification	<input type="checkbox"/> Community Based <input type="checkbox"/> Hospital Based

Section B: Substance Abuse 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-

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: (Choose one)	For MN program use Program Specifics/Modifiers: (Check all that apply)
Adolescent Adult Geriatric	Co-Occurring Services Recipients with Children Special Populations Medical Services
Methadone	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 • Fax # 1/855-454-8155