Wheelchair and Accessory Prior Authorization Request Form

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.

Member Information	
Today's Date	Member DOB Month / Day / Year
Member Name	Member Medica ID Number Group Policy
Member Phone Number (Area Code + Number)	
Prior Authorization Information	
DME Provider Name	DME Provider Address
DME Provider Telephone Number	City State Zip
DME Provider Fax Number	DME Provider Tax ID Number (TIN)
Proposed Date of Service	
DME Service Requested	Place of Service Code
Diagnosis/ICD-10 Code(s) **must be a billable code	
CPT Code(s)	
Relevant Inpatient Surgical ICD-10 Code(s)	
Ordering Provider Information	
Provider Name	Clinic Name
NPI Number	Address
Federal Tax ID Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number

Wheelchair and Accessory Prior Authorization Request Form
Purchase/Replacement/Repair Information

MEMBER NAME: _____
MEDICA MEMBER ID: _____

☐PURCHASE OF WHEELCHAIR OR ACCESSORY
ANTICIPATED DATE OF PURCHASE: _____

☐REPLACEMENT OF WHEELCHAIR OR ACCESSORY
DATE OF ORIGINAL PURCHASE OR DELIVERY: _____

ORIGINAL PAYER: _____

REASON FOR REPLACEMENT: _____

☐REPAIR OF WHEELCHAIR OR ACCESSORY_____
MAKE/MODEL/MANUFACTURER OF WHEELCHAIR OR ACCESSORY: _____
☐*You may provide/attach the manufacturer's specification sheet for this information*

ORIGINAL PAYER: _____

COST OF WHEELCHAIR OR ACCESSORY REPAIR: _____

COST OF WHEELCHAIR OR ACCESSORY REPLACEMENT: _____

Please note that written documentation from the medical record, including support for the DME service, must be submitted for all requests. *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. Submit form by:

- For group numbers that begin with IFB or C: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- For group numbers that begin with A **(excluding A0061 & A00500)**: Fax to 952-992-2396 or E-Mail to hpshealthmanagement@medica.com
- For all other group numbers **(including A0061 & A00500)**: Fax to 952-992-3556 or E-Mail to caremanagement@medica.com
- U.S. Mail to Medica, Utilization Management and Clinical Appeals, PO Box 9310, CP440, Minneapolis, MN 55440