

Clear Form

Methadone Maintenance Treatment (MMT) Opioid Replacement Therapy (ORT) Program
Medica Behavioral Health

Date: _____ Medica ID: _____

Member Name: _____ DOB: _____

Current Member Address: _____

Facility/Agency Name and Address: _____

Tax ID Number: _____

Assessment* completed on (Date): _____

Does your facility bill weekly or monthly?

Weekly Monthly

Dates of service: Start: _____ End: _____

Contact Person: _____ Phone Number: _____ Fax Number: _____

***Comprehensive assessment to be completed and/or most recent progress notes must be forwarded to Medica Behavioral Health at the onset of MMT/ORT services and on an annual basis while receiving services.**

Mail to: MN-CAC; PO Box 1459; MR: MN101-E700; MPLS, MN 55440-1459

or

Fax to 1/855-454-8155

Optum manages the Medica Behavioral Health program