Optum

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**:
Adolescent Residential Services	☐ Co-Occurring Services ☐ Recipients with Children ☐ Special Populations ☐ Medical Services
Adult Residential Services **Intensity Level** (for MN programs) ☐ High(>30hours/weekly) ☐ Medium(15-29hours/weekly) ☐ Low(5-14hours/weekly)	
☐ Detoxification	☐ Community Based ☐ 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