



Medica Behavioral Health: Substance Use Disorder Form

*** Please note- Form not required for Commercial membership as of 6/15/2024 and Medicaid as of 9/1/2024.**

Date: _____ Medica Member # _____

Member Name: _____ DOB: _____

Assessor Name: _____ Contact #: _____

Assess/Update Completed At: _____ Assessment Date: _____

Person Completing This Form: _____ Contact #: _____

ARE YOU MAKING A REQUEST FOR SUD SERVICES? *Use Medication Assisted Treatment request forms for MAT/MMT*

- NO** Please complete the demographic information above and attach the assessment for information purposes only
 - YES** You must **attach the most recently completed/updated assessment (e.g. Rule 25/31 or Comp Assess) or progress notes**
- For this request to be valid, **the information above and below must be completed in full**

SERVICE REQUEST (ONLY COMPLETE THIS SECTION IF YOU ARE REQUESTING COVERAGE OF SERVICES)

Facility/Program Name* _____ **Location:** _____

Facility Tax ID#: _____ **Facility Fax Number:** _____

*Check this box if no specific facility or program for services has been identified

Which type of service are you requesting? (Complete either the Outpatient or Residential portion, not both)

Acute Hospital Based Inpatient Services (Rehab/Detox) must be called in to 800-848-8327

OUTPATIENT ENTER REQUEST AS SERVICES WILL BE BILLED, IN HOURLY <u>OR</u> DAILY/PER DIEM UNITS		
<p style="text-align: center;"><u>Hourly/Per Hour Billing Only:</u></p> <p>Total # of Treatment Hours being requested, if providing treatment services billed hourly:</p> <p>Number of Group Hours _____</p> <p>Number of Individual Hours _____</p>	-OR-	<p style="text-align: center;"><u>Daily/Per Diem Billing Only:</u></p> <p>Total # of Program Days being requested, if providing treatment services billed as a per diem:</p> <p>Number of Days _____</p>
<p>Track:(Must choose one)</p> <p><input type="checkbox"/> Adolescent</p> <p><input type="checkbox"/> Services Adult Services</p> <p><input type="checkbox"/> Geriatric Services</p>	<p>Program Specifics/Modifiers (Must check all that apply)</p> <p><input type="checkbox"/> Co-Occurring Services</p> <p><input type="checkbox"/> Recipients with Children</p> <p><input type="checkbox"/> Special Populations</p> <p><input type="checkbox"/> Medical Services</p>	
<p>Dates of Service: Start date for this request: _____ End date for this request: _____</p>		

Treatment Coordination

T1016 U8 HN 15 min per unit

MEDICAID ONLY SERVICES

Total number of units (max 8 units per day) _____

Dates of Service: Start date for this request: _____ End date of this request: _____

Peer Recovery Support

H0038 U8 15 min per unit

MEDICAID ONLY SERVICES

Total number of units (max 8 units per day) _____

Dates of Service: Start date for this request: _____ End date for this request: _____

RESIDENTIAL FOR INITIAL SERVICE REQUESTS ONLY. FOR CONTINUED STAY REQUESTS CALL 1-800-848-8327**Track: (Must choose one)**

- Adolescent Residential Services
- Adult Residential Services

Adult Res Intensity Level (Adult only, MN-based programs only)

- High (> 30 hours/weekly)
- Medium (15-29 hours/weekly)
- Low (5-14 hours/weekly)

Program/Modifiers (for MN based programs only)

(Must check all that apply)

- Co-Occurring Services
- Recipients with Children
- Special Populations
- Medical Services

Has the member been admitted to the program? NO YES, ADMIT DATE _____**Fax to: Medica Behavioral Health at 1-855-454-8155**

Optum Behavioral is branded to Medica members as Medica Behavioral Health