

Prior Authorization Update Form

Please use this form for updates to existing approved clinical prior authorizations previously submitted via fax or electronic submission on the Availity Essentials Provider Portal.

Patient Information	
Today's Date	Patient DOB Month/Day/Year
Patient Name	Patient Phone Number (Area Code + Number)
Patient's ID Number Group:	Policy:

Prior Authorization Information
Authorization Number Requiring Update
Requested Update (please check all that apply): <input type="checkbox"/> CPT/HCPCS Code(s) <input type="checkbox"/> Units/Visits <input type="checkbox"/> Date(s) of Service <input type="checkbox"/> Other <input type="checkbox"/> Servicing Provider(s)
Please provide details of requested update:

Requesting Provider Information	
Provider Name	Clinic Name
Federal Tax ID	Address
NPI Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number

Submit form by utilizing the options below:

- For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440