



INSTRUCTIONAL AIDE

Send completed form to:

CARE GROUP REQUEST FORM

PLEASE NOTE: *This form is strictly to waive referrals or to print to the care system directory. It does NOT add a site to a Care System nor does it change reimbursement. Contact your Contract Manager to amend the Care System Contract.*

Contract
Implementation
E-mail address:
citda@medica.com
Mail Route CP350
PO Box 9310
Minneapolis, MN 55440-9310
Fax: (952) 992-3227

- 1) Request Date:
- 2) Requestor Name: 3) Phone #:
- 4) Fax #: 5) E-mail Address:
- 6) Care System Contact (if different from above):
- 7) Care System Name:

Care group Information:

- 8) Care Group Number(s):
- 9) Effective date: 10) Term date (if applicable):
- 11) Care Group Products: (Check those that apply)
- Advantage Plan (Allina) Elect – Medica Care System I
- Premier Essential – Medica Care System II
- MSHO / Dual Solution
- 12) Comments:

Reminder: Non-participating providers nor Facility providers can be care grouped.

Provider location to be care grouped:

13) Site #1 Federal Tax Identification Number:	
14) <input type="checkbox"/> Check here for all clinic locations (associated with this Tax Identification Number)	
15) Site Name:	16) Effective date: 17) Term date (if applicable):
Site Address:	18) For DME/IV/O&P requests only (check those that apply):
City: State:	<input type="checkbox"/> DME <input type="checkbox"/> IV therapy <input type="checkbox"/> O&P
Zip:	19) List in care system directory <input type="checkbox"/> yes <input type="checkbox"/> no
20) Comments:	

Complete page 2 for additional sites

Medica Network Management use only:	
21) <input type="checkbox"/> Networking (01, 04, 07, 12)	
22) <input type="checkbox"/> Internal Waiver (01, 04, 07, 12 & specialist in the Care System or clinic)	
23) <input type="checkbox"/> External Waiver (any practitioner/provider not part of a care system or clinic)	
24) Comments:	

25) CIT Initials:	26) Date completed:	27) Notification date and contact name:
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(Rev 7/04)

MEDICA Care Group Request Form Instructional Aid

NOTE: Incomplete forms will not be accepted and will be returned to the requestor.
NEITHER NON PARTICIPATING PROVIDERS NOR FACILITY PROVIDERS CAN BE CARE GROUPED.

The following information is required for all Care Group Request forms to ensure accurate data entry and proper claims processing. Please allow approximately 10 to 12 business days for completion of request.

Requestor Information (To be filled out by the Care System, Contract Manager, or Contract Specialist)

- 1.) Date-List the date the form is submitted.
- 2.) Requestor Name
- 3.) Requestor's phone number
- 4.) Fax number
- 5.) E-mail address-Confirmation of completion will be sent to the requestor.
- 6.) Care System Contact – For internal Medica requestors, list a contact name of the Care System
- 7.) Care System Name

Care Group Information (To be filled out by the Care System, Contract Manager, or Contract Specialist)

- 8.) Care Group Numbers-List all care group numbers related to the Care System. See the grid on the following page for the specific numbers of the larger Care Systems.
- 9.) Effective date-List the effective date of the site being loaded.
- 10.) Term date-List the termination date of the site being removed, if applicable.
- 11.) Care Group Products-Check all products that apply to the clinic that is being care grouped.
- 12.) Comment Section: This space can be used for special instructions or specific practitioners to be care grouped with in a specific site.

Provider location to be care grouped

Missing or incomplete information will delay the request and/or may result in the return of the request.

- 13.) Federal Tax Identification Number.
- 14.) **Check box – check this box if “all” clinic locations with the listed Tax number are included. If checked, then there is no need to complete page 2 for the additional sites.**
- 15.) Site name, address, city, state and zip.
- 16.) Effective date-List the effective date of the site being loaded.
- 17.) Term date-List the termination date of the site being removed, if applicable.
If adding or terming multiple sites with different dates, then use boxes 15 and 16. If adding or terming just one site, or all sites have same date, then it will be N/A.
- 18.) For Durable Medical Equipment (DME), Home Infusion (IV), Orthotics & Prosthetics (O&P) Only-please check all that apply.
- 19.) **List in care system directory – check “yes” or “no”.**
- 20.) Comment Section (Internal Medica requestors may list sites by Name and Group Practice number in comment section)
 - ◆ For additional sites, please use 2nd page of the form.

Medica Network Management and CIT use only This section is used when making changes to an existing care group or setting up a care group for the first time. Complete the box to determine the type of care grouping needed Networking, Internal or External.

- 21.) Networking (include Family Practice, Internal Medicine, OB/GYN, and Pediatricians)
- 22.) Internal Waiver (include the above practitioners and any specialists in the Care System or clinic).
- 23.) External Waiver (include any practitioner/provider not a part of a Care System or clinic).
- 24.) Comments

Contract Implementation use only:

- 25.) Initials-Initials of processor completing the transaction.
- 26.) Date Completed-List date transaction is completed.
- 27.) Notification Date and Contact Name (document when requestor was notified and the name of person contacted).