

MEDICA LATE CLAIM APPEALS FORM

To be used when a claim is submitted beyond the timely filing period.*

MEDICA®

DATE: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____

PROVIDER ADDRESS: _____

PLEASE SEND TO ADDRESS BELOW:

Medica
PO Box 30990
Salt Lake City, UT 84130

CLAIM INFORMATION:

Medica Member Name: _____

Medica Member I.D. Number: _____

Date(s) of Service: _____

Claim Number, if Applicable: _____

Check-Box Reminders:

- Claim Attached
 Appropriate Documentation Attached for Review

NOTE: BOTH THE CLAIM AND DOCUMENTATION ARE REQUIRED.

Requested by: _____ Phone Number: _____

* Please refer to the Medica Provider Administrative Manual for further details about Medica's timely filing policy and late claims appeals process.