Medical Technology Assessment Submission Form

Please complete and submit this form, along with any related supporting materials, to:
Medica Medical Affairs
Attn: Medical Technology Assessment Committee
P.O. Box 9310; Mail Route CP485
Minneapolis, MN 55440-9310
Fax: 952-992-2799

Name: ___________________________________________ Date: ________________

Phone: _____________________________________________________________________

Clinic Name: __________________________________________________________________

Address: ____________________________________________________________________

Name of Coverage Policy (as applicable): _______________________________________

Thank you for your inquiry regarding a Medica Coverage Policy. Medica makes every effort to conduct a thorough evaluation of new and emerging technologies using an evidence-based approach. The evidence used when making a determination includes well-designed and well-conducted investigations published in peer-reviewed journals, national physician specialty association and consensus or expert panel opinions, technology assessment reports, FDA and other regulatory approval status, and local physician input, including network specialty physicians and other local consensus opinions.

If you have additional recent literature that has been published in peer-reviewed journals or guidelines that you would like Medica to consider, please submit copies to the address listed above.

1. What are the indication(s) you would like Medica to consider? Please provide any specific criteria that patients must meet.

2. List or attach relevant peer-reviewed journal references that demonstrate the safety, effectiveness, and effect on health outcome of this technology for the above indication(s).

3. List or attach any relevant guidelines, consensus panel or professional association evaluations/recommendations, etc., about the use of this technology for the above indication(s).

4. Provide any operational information, if known:
   - Suggested ICD9 and/or ICD10 coding __________________________________________
   - Estimated yearly volume of use _______________________________________________
   - Other ____________________________________________________________________

Please provide or attach any additional information that may be helpful.

Note: Do not send any patient-specific information. Thank you.