*Please fill out the pre-authorization form **completely** and fax back with supporting clinical, codes, and doctors' orders. *** Incomplete requests will be pended until all information is received in writing by MCC. ****

Thank you,

UR Department

CONFIDENTIALITY STATEMENT:

Medical Management

Managed Care Concepts

AVAILABLE FAX NUMBERS: 409-886-5715 or 409-886-0409 or 409-670-0285

*** Please do not fax more than ONE request form at a time, even if they are for the same patient.

www.mcc-tx.com **PHONE** #866-750-2723 **ATTN:** Authorization Department

Check the appropriate service below, which pertains to your request:

- ❑ Outpatient Surgery
- ❑ Inpatient Hospital
- ❑ Physical Therapy
- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ Infusion Therapy
- ❑ DME
- ❑ Sleep Study
- ❑ SNF Care
- ❑ Home Health Care
- ❑ Hospice Care
- ❑ Injection
- ❑ CT
- ❑ MRI
- ❑ PET
- ❑ Outpt/NonSurgical
- ❑ _____

DATE of Request:_____ **Contact Name**:_____
From:_____ Phone #:(_____)_____Ext_____
Email Address: _____ Fax #: (_____)_____
Member Name:_____ Medical ID #/SS#:_____ *

Patient Name: _____**DOB**:_____/_____/_____
Member Phone #:_____ **Employer Ins Group # or Employer Name**:_____*
Member Address:_____
City: _____ State: _____ Zip: _____

Physician Name:_____ Phone #:(_____)_____
Address:_____ TAX ID#:_____
City: _____ State: _____ Zip: _____

Facility of Service:_____ Phone#: (_____)_____
Address: _____ TAX ID #_____
City: _____ State: _____ Zip: _____

Admission/Procedure Date: _____ Inpatient Outpatient

Diagnosis/ICD10 Code #: _____

Procedure/CPT Code #: _____

Requested # of visits_____ (PT,OT,ST or multiple procedures)

Reason for service/admission - Patient Clinical History:

_____

_____

_____

Is patient homebound? _____

TO EXPEDITE: PLEASE FILL OUT "**COMPLETELY**" AND "**INCLUDE**" WITH YOUR FAX REQUEST ANY CLINICAL NOTES, **DOCTORS ORDERS**, TEST RESULTS, WHICH WOULD ASSIST IN DOCUMENTING MEDICAL NECESSITY FOR THIS REQUEST. **Incomplete requests will be pended until all information is received in writing by MCC offices.**

Authorization #_____ **#of days/visits**_____