
*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:

The documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of the information or documents

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> DME | <input type="checkbox"/> CT |
| <input type="checkbox"/> Inpatient Hospital | <input type="checkbox"/> Sleep Study | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> SNF Care | <input type="checkbox"/> PET |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Outpt/NonSurgical |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Hospice Care | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Infusion Therapy | <input type="checkbox"/> Injection | <input type="checkbox"/> _____ |

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 _____