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**
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
- Injection
- CT
- MRI
- PET
- Outpt/NonSurgical
- Injection

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____________________