



MANAGED CARE
CONCEPTS *We Can.*

PATIENT INTAKE FORM

*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. ****

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



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 #: 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