TYPE OF SERVICE	
☐ Standard	☐ Expedite

PREAUTHORIZATION FORM

SECTION I: Patient Information

Last Name:	Maidden Name:	First Name:	Initial	Contract Number	Coverage Effective Date		
					Month	Date	Year

Do you have other health insurance? ☐ Yes ☐ No	Health Insurance Name	Other Insurance Contract Number	Effective Date			Medical Group
			Month	Date	Year	

Gender ☐ F ☐ M	Date of Birth			Age	Phone or Cell Phone Number	Alternate phone number	Fax Number
	Month	Date	Year				

Residential Address	City	Zip Code	Email

Mailing Address	City	Zip Code	Patient Signature

SECTION II : Requested Provider Information

Provider Name	License Number	NPI	Specialty	Office Phone Number

Email	Referral Date	Provider Cell Phone	Provider Fax Number

SECTION III: Service Requested

Please provide the diagnostic and procedure codes with the applicable description for the services requested.

ICD- 10 Code	Description	CPT/HCPCS Code	Description
1-		1-	
2-		2-	
3-		3-	
4-		4-	

Other (specify)

Select the Place of Service:

Inpatient

☐ Surgery ☐ Admission ☐ Skill Nursing Facility ☐ Other ☐ Rehab

Ambulatory

Place:

☐ Office ☐ Ambulatory Center ☐ Hospital

Select the Service and/or Procedure:

☐ Surgical ☐ Diagnostic

Other _____

Home Service

(Indicate service, date and amount)

☐ Skin Care
☐ Social Work
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Nutricionist
☐ Durable Medical Equipment
☐ Transportation
☐ Home Health Aide (HHA)
☐ Registered Nurse
☐ Medication

SECTION IV: Clinical Information

Describe the medical necessity for the service requested

Send the documents, physician's order, physical exam and lab results, along with the pre-authorization request, via fax to the MCS Receiving and Referral Unit: 787.620.1336/787.622.2434/787.622.2436.

Provider Information or Facility will offering the services

Provider name or facility (printed)	NPI	Provider/Facility Phone Number	Fax Number

An expedite or urgent request is applicable when the member life or health could be in danger by lack of access to treatment or service requested. The services requested out of this definition should be classified standard or not urgent. Incomplete forms may delay the pre-authorization process.

Provider Signature	Date	Service Date From			Service Date To		
		Month	Date	Year	Month	Date	Year

MCS Classicare is an HMO plan subscribed by MCS Advantage, Inc.

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