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Medical Case Management (MCM)

Authorization to Pay Non-Participating Providers

Enrollee name: _____

Enrollee ID: _____

MCM participant name: _____

Authorized designee of MCM participant: _____
(if applicable)

I authorize MESSA to issue reimbursement directly to non-participating providers for items and services authorized through the Medical Case Management Program.

I understand that reimbursement will be issued directly to the non-participating provider for all MESSA-authorized items and services, up to the established maximum, and less any applicable deductible, coinsurance or copayments, which are my responsibility.

This authorization shall remain in effect until revoked in writing.

_____ _____

MCM participant signature (or authorized designee) Date

Relationship to MCM participant: _____

MESSA®