Medical Case Management (MCM)

Authorization to Pay Non-Participating Providers

Subscriber name: _____

Subscriber ID: _____

MCM participant name: _____

Authorized designee of MCM participant: _____
(if applicable)

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

I understand that reimbursement will be issued directly to the Michigan 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.

I understand MESSA does not issue payment directly to **out-of-state** non-participating providers. Reimbursement will be issued to the subscriber and the subscriber will be responsible to pay the out-of-state non-participating provider.

This authorization shall remain in effect until revoked in writing.

_____ _____

MCM participant signature (or authorized designee) Date

Relationship to MCM participant: _____

MESSA®