MSA Meds
PROFESSIONAL ADMINISTRATORS

855-MSA-MEDS | MSAmeds.com
P.O. Box 190 | Barnesville, PA 18214

MSA Service Pre-Authorization Request Form

Please complete the information below and email to inquiry@msameds.com. Once the provided information is received, you will be contacted by a member of our team to provide determination or request further documentation/treatment notes necessary to complete your request.

Patient Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

Services Requested (CPT/HCPCS Codes and description): _____

Reason for Treatment (Diagnosis Codes and brief description): _____

Type of Injury the treatment is prescribed for (check one): ☐ Workers Compensation or ☐ Liability

Date of Injury the treatment is prescribed for: _____

Rendering Provider (NPI #): _____

Contact in Provider's office: _____

Provider's Practice Name: _____

Provider's Full Address: _____

Phone: _____

Fax: _____

Place of Service: _____

Date(s) of Service: _____