

## PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE Reserve Component

**Instructions:** Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then mails or faxes this form and supporting documentation to MMSO (address/FAX # below). *All blocks must be completed.*

### Section I – Patient Data

1. Branch of Service (✓ one)     USAR     USNR     USMCR     USAFR     ARNG     ANG     USCGR

2. Name (last, first MI):

3. Rank or Grade:

4. SSN

5. Patient Home Address (street, apt #, city, state, & zip):

6. DOB (YYMMDD):

7. Phone #: (include area code)

8. TRICARE Region (✓ one)

North     South     West

### Section II – Pre-Authorization Request

9. Date of injury/illness (YYMMDD):

10. Duty dates (YYMMDD):

From:

to:

11. Diagnosis or description of injury/illness (include ICD9 if available):

12. Eligibility documents were submitted to MMSO on: \_\_\_\_\_. If not, indicate what documents are attached by checking one or both of the following blocks:     LOD    or     Orders/Attendance Roster.

13. List follow-up care requested:

14. Provider Name:

14a. Provider POC and Phone #:

15. Medical Board Information (Date & MTF name):

16. Profile information/Limited Duty Board Information:

### Section III – Unit Certification of Eligibility

17. Name of nearest Military Treatment Facility: \_\_\_\_\_ which is located \_\_\_\_\_ miles from the reservist's/guard's  place of duty or  residence (✓ one).

18. Unit Name & Address (Unit name, staff symbol, code, street, bldg #, city, state, & zip etc.):

18A. Unit UIC/OPFAC

19. Unit POC (Name, Rank and Title):

19A. POC Phone # (include area code)

20. Certification: I certify that this individual is eligible for this care at government expense:

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

### DISTRIBUTION

**MAIL** this form/supporting documents to:  
MMSO Attn: Medical Pre-Authorizations  
P.O. BOX 886999  
Great Lakes, IL 60088-6999

**FAX** this form/ supporting documents to:  
**847-688-7394**  
Attn: Medical Pre-Authorizations