MACOMB COUNTY COMMUNITY MENTAL HEALTH

LABORATORY SERVICES UTILIZATION REVIEW
CLARIFICATION REQUEST

Date: _____

To: _____ Program/Services Unit: _____

Consumer: _____ Case #: _____

RE: Laboratory Tests Ordered:

1 _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

In reviewing the above laboratory tests ordered for your patient, it has been determined that clarification is needed for their use.

PLEASE CLARIFY THE FOLLOWING: _____

PHYSICIAN RESPONSE

Please PRINT clearly. You may write on back if needed.

_____
Physician Signature/Date

Please send your response by Mail or Fax to:

_____
Name of Medical Director, M.D.

22550 Hall Road
Clinton Twp., MI 48036
Tel: (586) 948-0240
Fax: (586) 948-0242