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: _____

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PHYSICIAN RESPONSE

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

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_____
Physician Signature/Date

Please send your response by mail or fax to:

_____
Name of Chief Medical Officer, M.D.
22550 Hall Road
Clinton Township, MI 48036
Telephone: (586) 465-8323
Fax: (586) 469-7674