

MACOMB COUNTY COMMUNITY MENTAL HEALTH

PRIOR AUTHORIZATION REQUEST Subsidized Laboratory Services Program

Date: _____

TO: CHIEF MEDICAL OFFICE, MCCMH

From: _____, MD/RN
Physician Name (Please PRINT)

Program / Services Unit: _____
Ph #: _____
Fax #: _____

Consumer Name: _____ Case #: _____ DOB: _____

<u>LABORATORY TESTS</u>	<u>CODE NO. (if known)</u>	<u>RATIONALE</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Consumer Diagnosis:

M.D./RN Signature: _____

Please FAX to: _____ Chief Medical Office, MCCMH

FAX#: 586-469-7674

☐ Approved

P.A. No.: _____

☐ Not Approved

Comment: _____

(MCCMH Chief Medical Office, credentials, date)