MACOMB COUNTY COMMUNITY MENTAL HEALTH
Subsidized Laboratory Services Program

P.A. No.: _____

LABORATORY TEST(s) ORDER FORM
PRIOR AUTHORIZED

Consumer Name _____ Case #_____

DOB

Licensed Prescriber: _____ _____

Bill To: Macomb County CMH
19800 Hall Road
Clinton Township, MI 48038

Clinic Name_____
Acct #:_____
Address:_____
Ph:_____
Fx:_____

Physical Dx Code_____ Behavioral Dx Code_____

Diagnosis codes must be medically appropriate for patient's condition and consistent with documentation in medical record. For your convenience, this is a partial list of Physical Diagnosis Codes which can be found in the ICD-9-CM Book.

V70.0	*Gen. Medical Exam (Adult)*	**242.90**	*Hyperthyroid*
V20.2	*Gen. Medical Exam (Child)*	**251.2**	*Hypoglycemia*
276.9	*Electrolyte Imbalance*	**244.9**	*Hypothyroid*
573.3	*Hepatit*is	**V22.2**	*Pregnancy*
790.6	Hyperglycemia	**593.9**	*Renal Disease*
401.1	Hypertension	**246.9**	*Thyroid Disorder*

Tests Requested

The following laboratory tests have received prior approval:

CODE NO. LABORATORY TESTS ORDERED

_____
_____
_____
_____
_____

NOTE: THIS FORM IS TO BE USED ONLY AFTER APPROVAL OF TEST(S) USING MCCMH FORM #293 "PRIOR AUTHORIZATION REQUEST"

Original copy: Consumer to take to participating Laboratory