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: MCCMH Chief Medical Office
19800 Hall Road
Clinton Township, MI 48038
Tel: (586) 465-8323
Fax: 586-469-7674