MACOMB COUNTY COMMUNITY MENTAL HEALTH

PRIOR AUTHORIZATION REQUEST

Subsidized Laboratory Services Program

Date: _____

TO: _____
(*Name of Medical Director, credentials)*

From: _____,MD
Physician Name (Please PRINT)

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

Consumer Name: _____ Case #: _____ DOB: _____

LABORATORY TESTS	CODE NO.	RATIONALE

Consumer Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Physician Signature: _____

Please FAX to: _____
(*Name of Medical Director, credentials)* FAX#: (586)465-8320

□ Approved P.A. No.: _____ □ Not Approved

Comment: _____

_____

_____

_____

_____

_____
(*Signature of Medical Director, credentials)* Date

MCO 2-022 - Exhibit C MCCMH #293 (3/06)