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: _____

LABORATORY TESTS	CODE NO.(if known)	RATIONALE

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)