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