



PROFESSIONAL CLAIM DOCUMENTATION Review Area
FAX COVER LETTER **FAX #: 866-584-8081**

TO: Ambulatory Claims Review Unit, Medicaid Payments Division-Claims Processing
 Bureau of Medicaid Financial Management, Medical Services Administration
 Department of Community Health, State of Michigan

FROM:

Facility Name:	
Contact Person Name/ Position:	
Contact Person's Phone #:	
Fax #:	
NPI #:	

PATIENT MEDICAID ID #:	
Provider Type and ID #: (i.e., TTDDDDDDDD)	
DATE OF SERVICE:	
NUMBER OF PAGES (Including Cover Page):	
Required fields highlighted above	

DOCUMENTATION TYPE	CHECK ALL THAT APPLY
ABORTION FORMS: MSA 4240 & MSA 1550	
ACKNOWLEDGE OF HYSTERECTOMY INFORMATION MSA 2218	
AMBULANCE INFO	
BILLING TIME LIMIT / REMITTANCE ADVICES/CRN'S	
HIGH COST CHARGES MANUFACTURER INFO	
MEDICAL RECORDS	
ADMIT/DISCHARGE REPORT	
ER REPORT	
HISTORY AND PHYSICAL	
IMAGING AND DIAGNOSTIC SERVICES REPORT	
LABOR & DELIVERY NOTES	
OP REPORT	
PATHOLOGY REPORT	
MEDICARE EOB &/OR OTHER INSURANCE INFO	
NDC DRUG DOSING AND COST INFO	
PRIOR AUTHORIZATION	
VOLUNTARY STERILIZATION CONSENT/MSA 1959	

MDCH Provider Hotline: 1-800-292-2550

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