



**CONSENT FORMS APPROVAL AREA**  
**FAX COVER**  
**FAX: 866-229-6675**

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

**Completion of all highlighted fields is required.**

**FROM:**

<b>Facility or Group/Individual Name:</b>	
<b>NPI Number:</b>	
Provider Type and ID Number, if applicable: (i.e., TTDDDDDDDD)	
<b>Patient Medicaid ID Number:</b>	
<b>Date of Service:</b>	
<b>Contact Person Name/ Position:</b>	
<b>Contact Person's Phone Number:</b>	
<b>Fax Number:</b>	
<b>Number of Pages (Including Cover Page):</b>	

**DOCUMENTATION TYPE INCLUDED**  
**(Check All that Apply)**

- INFORMED CONSENT TO STERILIZATION (MSA-1959)
- ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION (MSA-2218)
- MEDICAL RECORDS (UPON MDCH REQUEST ONLY)
 

<input type="checkbox"/> ADMIT/DISCHARGE REPORT	<input type="checkbox"/> IMAGING AND DIAGNOSTIC SERVICE REPORT
<input type="checkbox"/> ER REPORT	<input type="checkbox"/> LABOR & DELIVERY NOTES
<input type="checkbox"/> HISTORY AND PHYSICAL	<input type="checkbox"/> OP REPORT
	<input type="checkbox"/> PATHOLOGY REPORT

**Any Questions, call MDCH Provider Inquiry: 1-800-292-2550**

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