Michigan Department of Community Health
MDCH
Rick Snyder, Governor
Nick Lyon, Director

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 Operations
Department of Community Health, State of Michigan

Completion of all highlighted fields is required.

FROM:

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

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)
- ☐ ADMIT/DISCHARGE REPORT
- ☐ ER REPORT
- ☐ HISTORY AND PHYSICAL
- ☐ IMAGING AND DIAGNOSTIC SERVICE REPORT
- ☐ LABOR & DELIVERY NOTES
- ☐ OP REPORT
- ☐ PATHOLOGY REPORT

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