



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., TTDDDDDDDD)	
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
 - IMAGING AND DIAGNOSTIC SERVICE REPORT
 - ER REPORT
 - LABOR & DELIVERY NOTES
 - HISTORY AND PHYSICAL
 - OP REPORT
 - PATHOLOGY REPORT

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

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