

Drug Test Authorization

Authorization Number	Version Number	New/Modified

Service Area	County	Collection Agency

Fund Source			
<input type="checkbox"/> Child Protective Services Incident Number:	<input type="checkbox"/> Court Ordered Docket Number:	<input type="checkbox"/> Child Welfare	<input type="checkbox"/> Other (specify):

Adult(s) Referred	FACS ID	Date of Birth	Medicaid-Eligible	Relationship
Address				

Test Type	Protocol	Stop Date	Retest (Y/N)	Collection Mode	Total Cost

Child(ren) Referred	FACS ID	Date of Birth	State ID	Medicaid-Eligible
Address				

Test Type	Protocol	Stop Date	Retest (Y/N)	Collection Mode	Total Cost

Request Initiated By:	Phone: ()
	Email:
	Fax: ()

Date of Authorization	Authorization Expiration	Total Cost

Approved By:	Approved Date