

**ADD-ON TEST REQUEST FORM
:: FAX TO (754) 816-3162 ::**

Account name: _____ **Today's Date:** _____

Account Number: _____ **Account Phone #:** _____

Ordering Physician: _____

Patient Name: _____

Original Requisition #: _____

Original Date Ordered: _____

BILL: ___ Medicare ___ Medicaid ___ Patient ___ Client ___ Other ___

Test Number	Test Name	ICD-9 Diagnosis Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorized Signature

Date

X _____ / ___ / _____

Once we receive the add-on form, it will be submitted to the processing department for verification to make sure there is enough sample to run the test....Processing department will then call you back to let you know if we will be able to add the test requested or Not .

For office use only

Received By: _____ Time: _____ Date: _____

Confirmation With Client By: _____ Time: _____ Date: _____