



# ADD-ON TEST REQUEST FORM

## FAX TO (754) 816-3162

Account Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Account Number: \_\_\_\_\_ Account Phone #: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Account Contact #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Original Requisition #: \_\_\_\_\_ Original Date Ordered: \_\_\_\_\_

BILL: Medicare  Medicaid  Patient  Client  Other

Test Number	Test Name	ICD-9 Diagnosis Code

Authorized Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PROCESSING COMMENTS:** \_\_\_\_\_

**IMPORTANT INFORMATION**

- Please call Customer Service to confirm receipt of Add-On Form (954) 430-5775.
- Add-On form will be submitted to the Processing Dept. for verification to make sure test(s) can be processed.
- The Processing Dept will call back if we are unable to process the Add-On request.

**\*For Office Use ONLY\***

Received By: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Confirmation with Client: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_