



ADD-ON AUTHORIZATION FORM

Date: _____ Req. #: _____

Patient Name: _____

Name: _____ DOB: _____

Account Number: _____ Account Name: _____

Dear Provider,

Please complete this form to add any test(s) or panel. Physician's or authorized person's signature is required by CLIA Regulations to verify your request. Upon completion, please fax the form back to the laboratory at **(855)217-3362**. Your prompt response will ensure timely processing of your request.

TEST CODE	ADD-ON TEST

ICD-9 DIAGNOSIS CODE

By signing on this form, the provider certifies that the information is correct.

Authorized Signature:

Date: