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ADD-ON TEST REQUEST FORM

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CLIA License #11D0703390 State of Georgia License #044-146

Instructions to Physician/Health Care Provider: Federal law requires us to keep a written record of completed test requests or test modifications. Please complete all the information on this form for our records. When completed, you may fax the form directly into Support at **678.597.5669** or mail it to the address above attention: Customer Services Coordinator. If you have any questions, please call 678.597-5658 for our Customer Services Dept. Please return the form to us within 24 hours of receipt.

Patient Name: _____ Date of Birth: _____

Ordering Physician Printed Name: _____

Ordering Physician Signature: _____ Date: _____

Telephone: _____ Email: _____

Add-on tests requested: _____

Referring Facility Notification

You must inform your reference facility and have approval to proceed with the requested additional testing. We bill only the referring facility and do not directly bill patient insurance.

Add-on testing without providing billing approval may not be processed & resulting delays may affect sample quality.

Billing Address:

Authorizing Reference Laboratory Staff:

Printed Name

Signature

Date