Test Add-on Request Form

Fax to Client Response Center: 214-237-1731

(NO COVERSHEET REQUIRED)

Please perform the following test(s) on the case indicated below:

TEST	ICD-10
____________________	____________________ (Required)
____________________	____________________ (Required)
____________________	____________________ (Required)

Today's Date: ____________________

Client Account Number: ____________________

ProPath Accession #: ____________________

Date of Collection: ____________________

Patient Full Name: ____________________

Patient Date of Birth: ____________________

Ordering Clinician Signature: ____________________

I attest that I am authorized to order the test(s) and that the test(s) is medically necessary for my patient.

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