# LABORATORY TEST ADD-ON FORM

CLINIC NAME: _____ ORDERING PROVIDER: _____

CLINIC PHONE: _____ CONTACT NAME: _____

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

ORIGINAL DRAW DATE: _____ ACCESSION/ORDER NUMBER (IF KNOWN): _____

| TEST CODE (if known) | TEST NAME | ICD-10 CODE (insurance requirement) |
|---|---|---|
| | | |
| | | |
| | | |

Other notes or comments: _____

_____

_____

Is a new specimen being submitted with this request? **YES** ○ **NO** ○

Upload this form to the Add-on Testing Request page on our website. For urgent requests, please call Client Services at (208) 529-8330.

**PHYSICIAN CONSENT & AUTHORIZATION**

_____

PROVIDER SIGNATURE

_____

TODAY'S DATE

The electronic submission of this form constitutes authorization by the ordering provider for Express Lab to perform the additional testing as requested on this form and to use the same billing method as indicated on the original requisition. The ordering provider further acknowledges that if this additional testing is denied by insurance, Express Lab reserves the right to bill the provider's client account.

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