



TEST & DIAGNOSIS CODE ADD ON REQUEST FORM

To maintain accuracy and compliance, please complete the information below for all ordering physicians. Keep a copy of this form on file for any physician additions or deletions in the future.

Thank you for your assistance.

Kindly fax immediately to 267-525-2488

DATE:

CLIENT NAME:

Dear Client:

The following tests / ICD-10 codes were verbally added on patient

ACCESSION # _____ DATE: _____

Federal regulations require written authorization on all tests ordered by clients. Please review, sign, and fax this document to ADL at your earliest convenience.

TEST NAME	DIAGNOSIS CODE (ICD-10)
1.	1.
2.	2.
3.	3.
4.	4.

Signature of Ordering Physician: _____

Printed Name of Client's Authorized Representative: _____

FAX THIS FORM TO 267-525-2488 ~ NO COVER SHEET REQUIRED

3520 Progress Drive Suite C | Bensalem PA 19020
Phone: 267-525-2470 | Fax: 267-525-2488
