



DATE: \_\_\_\_\_

**MSS CLINICAL**

# TEST ADD ON AUTHORIZATION FORM

PATIENT NAME: \_\_\_\_\_

PATIENT DOB: \_\_\_\_\_

ORDERING PROVIDER: \_\_\_\_\_

REQUESTING ADD ON: \_\_\_\_\_

## TESTS TO BE ADDED:

TEST NAME	TEST CODE	DIAGNOSIS CODE

**\*SIGNATURE OF AUTHORIZED PERSON TO ADD ON TESTING FOR ABOVE PATIENT:**

\_\_\_\_\_

### LAB USE ONLY:

ACCESSION NUMBER: \_\_\_\_\_

DATE SAMPLE WAS RECEIVED: \_\_\_\_\_

COMPLETED BY: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

*The Future of Laboratory Testing*

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