XERON
Clinical Laboratories

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 718-762-3350

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 XCL 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 718-762-3350 ~ NO COVER SHEET REQUIRED

48-25 36TH STREET | LONG ISLAND CITY-QUEENS 11101
Phone: 866-937-6652 | Fax: 718-762-3350