MNG LABORATORIES
A LabCorp Company

Add-On Test Request Form

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Patient and Specimen Information

Patient Last Name	Patient First Name
Patient ID #	Date of Birth [MM/DD/YYYY]
Diagnosis/ICD-10	Collection Date [MM/DD/YYYY]

Gender ☐ Male ☐ Female

Specimen Type ☐ Whole Blood ☐ Buccal Swab ☐ CSF ☐ Urine ☐ Fibroblasts ☐ Plasma/ Serum ☐ Muscle ☐ DNA Tissue:_____

Add-On Testing (MNG Test Number & MNG Test Name Required)

TEST 1		TEST 3	
TEST 2		TEST 4	

Referring Physician Information

Physician Name	NPI # or equivalent *(Required)*
Facility / Organization	Signature
Report Delivery ☐ Fax ☐ Email	Phone

Billing Information *(REQUIRED)*

Self-Pay? ☐ Yes If yes, **MUST** include payer contact name & details below. Payment must be received in full prior to testing.

Facility		Contact Name
Billing Address		
City, State, Zip Code		
Phone	Fax	Email

Results

Authorized Recipient Name	Authorized Recipient Name
Facility Phone	Facility Phone
☐ Fax	☐ Fax
☐ Email	☐ Email