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
Facility Address City, State, Zip Code ☐ Same as billing	
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