



CLIENT RESPONSE CENTER

FAX TO: (214) 237-1731

(NO COVERSHEET REQUIRED)

Test Add-on Request Form

Please perform the following test(s) on the case indicated below:

| <u>TEST</u> | <u>ICD-10</u> |
|-------------|---------------|
| _____       | (Required)    |
| _____       | (Required)    |
| _____       | (Required)    |

Today's Date: \_\_\_\_\_

Client Account Number: \_\_\_\_\_

ProPath Accession #: \_\_\_\_\_

Date of Collection: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_

For assistance, please call the Client Response Center at (800) 258-1253.

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