



MNG LABORATORIES
A LabCorp Company

Add-On Test Request Form

5424 Glenridge Drive NE | Atlanta, GA 30342 USA | phone: 844.TESTMNG | fax: 678.225.0212 | mnglabs.com

Patient Name _____ DOB _____

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

TEST 1		TEST 3	
TEST 2		TEST 4	

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Specimen Type <input type="checkbox"/> Whole Blood <input type="checkbox"/> Buccal Swab	<input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Fibroblasts	<input type="checkbox"/> Skin [For Culture] <input type="checkbox"/> Plasma <input type="checkbox"/> Muscle <input type="checkbox"/> DNA Tissue: _____

Referring Physician Information

Referring Physician Name	Print	Signature
Referring Physician NPI # [Required] or international equivalent		
Facility / Organization	Phone	
Select and Provide Email or Fax for Report Delivery	<input type="checkbox"/> Email	<input type="checkbox"/> Fax

Billing Information **(REQUIRED)**

Self-Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, payer contact name & phone number:
Facility Responsible for Payment	Phone
Facility Contact Person	Email
Facility Billing Address 1	Fax
Facility Billing Address 2	
City, State, Zip Code	

Results (sent by secure HIPAA-compliant email or fax)

Authorized Recipient Name	Authorized Recipient Name
Facility	Facility
Phone	Phone
<input type="checkbox"/> Fax <input type="checkbox"/> Email	<input type="checkbox"/> Fax <input type="checkbox"/> Email