Add-on/Change form

Allina Health LABORATORY

*In order to perform additional testing on a previously received specimen, or to change patient demographic information, the laboratory needs written authorization. Complete this form and **fax** to Allina Health Laboratory Client Services at (612) 863-4067. Please contact our Client Services staff with any questions at (612) 863-4678, option 1, or (800) 281-4379.*

Facility name: _____ Date: _____

Contact name: _____ Phone: _____

Patient name: _____ DOB: _____

Patient address: _____

MRN: _____ Sex: ☐ Male ☐ Female

Provider full name: _____

Provider Signature: _____ (*Required*)

Billing information: ☐ Bill Client ☐ Bill Patient /Insurance

Diagnosis (ICD code or descriptive narrative)_____

Diagnosis information must be for current test(s) being added.

☐ **Add-on test request:**

Original test(s):_____Original order date:_____

Added test(s):_____

☐ **Change request**

Describe change requested: billing, patient demographics* (spelling, MRN, DOB), diagnosis, physician/Provider ID, date*/time* collected, etc. **Generates a new report*

_____

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For Allina Health Laboratory use only:

Submitter (SMT): _____ RQ #_____ Specimen # _____