REQUEST FOR ADDITIONAL INFORMATION FORM & INSTRUCTIONS

Account #:	**Client Name:**	**Ordering Physician** :		
Address:		**City:**	**State:**	**Zip:**

The following request for additional information is being provided to obtain the required missing/incomplete patient demographics and/or insurance information, the DX code which was not submitted on the original requisition, or the DX code which was not coded to the highest level of specificity for the laboratory test(s) ordered. An **XXX** in the box means the information is not required.

For your convenience, enclosed are links to the National and Local Coverage Determination Guidelines relevant for the testing provided by MD Labs along with CMS Coverage Guidelines. **Medicare will only pay for the tests that are medically reasonable and necessary based on the clinical condition of each individual patient.**

Date of Request:	
Req #:	
Last Name:	
First Name:	
DOB	
Date of Service:	
Invalid DX Code(s) Provided:	
Provide Valid DX Code(s): ***Signature required below***	
Medical Records Request:	
Patient Address: ***Attach Patient Face Sheet***	
Provide Insurance Information by entering data below, attaching front/back copy of card, or attaching EMR Lab Req printout	
Insurance Company Name:	
Address 1:	
Address 2:	
City, State Zip:	

Send completed requests by:

Email to **BillingQuestions@mdlabs.com, or**
FAX to **775-737-9133,** Attn: Billing, or
Mail to MD Labs 10715 Double R Blvd, Ste. 102 Reno, NV 89521 Attn: Billing

Should you have any questions or concerns please call our Billing Department at **775-499-5150**.

I have documentation supporting the medical necessity of these laboratory test(s) in the patient's medical record for the date of service above. The patient's medical records will be update to reflect the appropriate and/or missing diagnosis codes reflected above. I understand that the Office of the Attorney General requires such documentation in the patient's medical record, including the date of service, diagnostic code(s), tests ordered and documentation to support medically necessity. **Ordering Physician's Wet Signature is required when you are providing any DX information.**

Physician Name: _____

Physician Signature:_____Date: _____