SSMHealth
St. Mary's Hospital
Madison
Laboratory Services

Date of Request: _____

Client Name: _____

Contact Person / Telephone #: _____

Patient Name: _____

Date of Birth: _____

Patient Address: _____

Medicare (MC) #: _____ Medical Assistance (MA)#: _____

Physician Name (First, Last Required): _____

Authorizing Physician Signature _____

Date of Service: _____

Test Name(s): _____

ICD Diagnosis Code(s): _____ New Diagnosis ? Yes ____ No ____

** If a new diagnosis code is submitted, an authorizing physician signature is required by MC / MA **