DART
MEDICAL LABORATORY INC.
140 58th ST. BUILDING A UNIT 3L● BROOKLYN, NEW YORK 11220●TEL.:(866) 335-DART● FAX: (718) 934-2003

PHONE REQUEST AUTHORIZATION

REQUESTING PHYSICIAN:_____

Dear Doctor,

According to our records, the following patient had tests verbally added to their original orders. Since these tests are not included on the original requisition, we are requesting written authorization. Please verify the information, sign the authorization and fax the form to **718-934-2003**.

PATIENT NAME:_____

REQUISITION DATE: _____

ADDED DATE: _____

TEST:_____

ICD-9:_____

SIGNATURE/STAMP:_____