Physician Name: _____

NPI #: _____

Affiliation: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Account Number: _____

Patient Name: _____

Patient DOB: _____

Patient Address: _____

Date: _____

ICD-10 Codes
Please provide the appropriate ICD-10 code(s).

○ _____

Please perform the test(s) checked below:

- ☐ **816387** – Early Sjögren's Syndrome Profile (PSP, CA-6, SP1) lgG/M/A for each
- ☐ **012708** – Sjögren's Ab, Anti-SS-A/Anti-SS-B
- ☐ **164947** – Anti-Nuclear Antibody (Hep-2)
- ☐ **006502** – Rheumatoid Factor lgM

_____

Signature