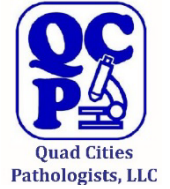




DIAGNOSIS CHANGE REQUEST



This form is to be use for Requesting Physicians to send post-order requests for changes on diagnoses codes directly to our Billing Department.

Date: _____

Send completed form to: Metro Lab/APS Billing

Fax: 1-419-866-5453

- **ALL codes must be sent in ICD-10 format.**
- **This form is not valid without signature.**
- **ALL fields are required for change.**

REFERRING PRACTITIONER (please print): _____

OFFICE PHONE: _____

OFFICE FAX: _____

Patient Name: _____

Date of Birth: _____

Account #: _____

Date of Service: _____

Test: _____	Current DX: _____	DX Change: _____
Test: _____	Current DX: _____	DX Change: _____
Test: _____	Current DX: _____	DX Change: _____
Test: _____	Current DX: _____	DX Change: _____

SIGNATURE OF REFERRING PRACTITIONER REQUIRED:

Thank you!

Please deliver this facsimile transmission to the above addressee. If you did not receive all of the pages in good condition or if you have received this communication in error, please advise by calling the telephone number above. The communication is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient, employee, or agent responsible for delivering the communication, you are hereby notified that nay dissemination, distribution, or copying of this communication is strictly prohibited.