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!