

## Diagnostic Change Request

Client Name \_\_\_\_\_

Client Account Number \_\_\_\_\_

If a diagnosis code needs to be changed on an order, complete the information below and fax this form to 630.938.3407.

**All diagnosis changes require a physician's signature.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Service \_\_\_\_\_

• Add DX(s) \_\_\_\_\_

• Remove DX(s) \_\_\_\_\_

• Replace with DX(s) \_\_\_\_\_

• Switch order of existing DX(s): 1st \_\_\_\_\_ 2nd \_\_\_\_\_

3rd \_\_\_\_\_ 4th \_\_\_\_\_

Time \_\_\_\_\_ Date \_\_\_\_\_

**Physician's signature** \_\_\_\_\_

Form completed by \_\_\_\_\_ Phone \_\_\_\_\_