Amending Diagnosis Information
For Outpatient Lab Services Only

Return form to:
Fax form to: 802-847-5905  or  E-mail to: Lab Billing@UVMHealth.org

Date of change request: _________________________ Date of service: ______________________________

Please indicate what needs to be corrected:

☐ Add diagnosis  ________________________________________________

☐ Remove diagnosis  ____________________________________________

☐ Change Order of diagnoses  ____________________________________

Reason for amendment:

You are responsible for ensuring that the accurate diagnosis is included in the patient’s medical record.

Physician authorizing this change:

Physician’s Name (print): ________________________ Physician’s Location: ______________________

Physician’s Signature:  ________________________________________________

Date: _______________  Time: __________________

Internal use only:

Person receiving change request: ________________________ Date change made in

patient’s billing record: ______________________

Note: This form must be scanned to the patient’s medical record.