THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

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.