Indiana University Health

Physician Diagnosis Change/Add Request Form

Patient Name: _____ **Date of Birth**: _____

IU Health MR#: _____ **Date of Service**: _____

IU Health Account#: _____

Physician Name: _____

Department: _____ **Location**: _____

Change Diagnosis From:

_____

_____

Change/Add Diagnosis To:

_____

_____

_____

Reason For Change/Add:

_____

_____

_____

_____

Physician Signature: _____

Date of Request: _____

Fax completed and signed form with any supporting documentation to HIM (Medical Records) at fax number: (317) 968-1203