



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:

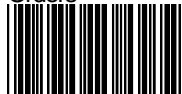
Reason For Change/Add:

Physician Signature: _____

Date of Request: _____

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

Orders



7 2 3 9

Physician Diagnosis Change/Add Form

Medical Record - Original

T-5