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[www.helixmdx.com](http://www.helixmdx.com) | **CLIA:** 23D1104676

## Diagnostic Change Request Form

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 888.275.5224.  
All diagnosis changes require a physician's signature.

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

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

- Remove DX(s): \_\_\_\_\_
- Replace with DX(s): \_\_\_\_\_
- Switch order of existing DX(s): 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  
3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_

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

Form completed by: \_\_\_\_\_ Phone# \_\_\_\_\_

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

Form completed by: \_\_\_\_\_ Phone# \_\_\_\_\_