773-1191/04-29-16

Patient Label
Name: ____________________
DOB: _____________________
M#:______________________

Medical Records Diagnosis Correction Form

Patient Name: ____

Patient DOB: ____

Date of Service: ______________________________________

Correct Diagnosis to be coded: ____

____

☐ Replace with above diagnosis ☐ Add above diagnosis to already coded diagnosis

Physician Signature: ____

Date: ____________________________

PLEASE RETURN TO THE MEDICAL RECORDS DEPARTMENT OR FAX BACK TO 406-414-1069.

Physician signature must be on the form before a diagnosis can be changed on an account. This form will serve as a written request by the physician for classification of diagnosis code(s) and be included in the patient's chart.