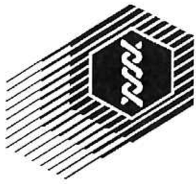

REPORT CHANGE REQUEST

DPMG requires a written statement from the physician's office for **all** changes including patient name, date of birth, and physician name changes. Please provide the correct information, sign the form and FAX BACK TO: 916-446-9330

Date : ________________ Name of person filling out the form: ________________________

Physician : ______________________________ DPMG Report # ______________________

Please Check Correction Requested:

PATIENT NAME CHANGE: _____
BIRTHDATE: ____
REFERRING PHYSICIAN: _____
SPECIMEN SITE: _____
OTHER: ______

FROM: ______________________________ TO: ____________________________________

For change of patient name please also provide:

Patient's Home Address: ____

DOB: _____________ Gender: _______________ Patient Telephone #: _____________________

Patient's Insurance: ____________________________ Insurance ID# ______________________

Please also fax a copy of the patient's insurance card.

Any other additional information: ____

Physician or authorized designee signature: ____

Physician or authorized designee signature is required for all changes.

DPMG USE ONLY:

REPORT CORRECTION RECEIVED AND COMPLETED BY:

SIGNATURE: ____________________________ DATE: _________________

SCAN FORM WITH THE CASE AND GIVE ORIGINAL TO TRANSCRIPTION FOR AMENDMENT

T:\Customer Service\Forms\REPORT CHANGE REQUEST.doc