ACCU | REFERENCE MEDICAL LAB

1901 East Linden Avenue
Suite 4
Linden, NJ 07036
Phone 908-474-1004
Fax 908-474-0032
www.accureference.com

CORRECTION FORM

Account Number on the report ______________________________

Account Name on the report____

Date of Service ____/_____/_____

Correct Patient Name ____

(Please Print Clearly)

Name On Requisition ____

Correct Date of Birth ____/____/____

Date of Birth on Requisition ____/____/____

******Other information needed to be changed, i.e. Client/Provider number, Gender, Race, DOS, etc******

____

____

____

____

____

____

This letter is to clarify and to request the above patient information to be corrected. By signing this letter, you give authority to Accu Reference Medical Lab to change and correct the above patient's information.

____ DATE _____/______/_____

(Physician or Authorized Personal Signature)