

# Discrepancy Resolution Form

Please complete the blank fields and fax back to 866.688.3280  
or email form to [clientservices@informdx.com](mailto:clientservices@informdx.com)



## PATIENT INFORMATION

Patient Name	
Inform Diagnostics Accession No.	Date of Birth

## CLIENT INFORMATION

Client Name		Client ID
Address		
City	State	Zip
<b>I authorize Inform Diagnostics to use the authorized resolution described below. Form must be signed by authorizing clinician (or designee).</b>		
Print Name	Title	
Center/Hospital/Practice		
Signature	Date	

## DISCREPANCY INFORMATION

### Check any that apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Specimen mislabeled                             | <input type="checkbox"/> Specimen unlabeled                             | <input type="checkbox"/> Specimen is missing |
| <input type="checkbox"/> Requisition has incorrect information           | <input type="checkbox"/> Requisition is incomplete or missing           |  |
| <input type="checkbox"/> Patient billing sheet has incorrect information | <input type="checkbox"/> Patient billing sheet is incomplete or missing |  |
| <input type="checkbox"/> Specimen & requisition don't match              |   |  |

### Description of discrepancy

### Authorized resolution

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