PROVIDER INFORMATION CHANGE REQUEST FORM

Please use this form to request changes to a physician's or practice's information on file with Bio-Test Laboratory, including contact details, address, fax number, email, or report delivery preferences. Please submit completed forms to itsupport@bio-test.ca.

DATE OF REQUEST: _____

Concern:	☐ Clinic/Location or ☐ Physician
Name of the clinic or physician:	

REQUEST TYPE	
☐	Update Physician Information
☐	Update Clinic/Practice Information
☐	Add New Practice Location
☐	Remove Practice Location
☐	Remove Physician from Location
☐	Inactivate / Retired Physician
☐	Other: _____

INFORMATION TO BE UPDATED		
Information	**Current Information**	**New Information**
Physician Information		
Practice Name		
Practice Address		
Phone		
Fax		
Additional Comments:		

REQUESTED BY

Name: _____

Phone/Email: _____

Signature: _____