# Discrepancy Resolution Form

Please complete the blank fields and fax back to **1.855.856.0655** or email form to **info@fulgentoncology.com**

## Patient Information

LAST NAME | FIRST NAME

ACCESSION # | DATE OF BIRTH (MM/DD/YYYY)

## Client Information

CLIENT

ADDRESS

CITY | STATE | ZIP

**I authorize Fulgent Oncology to use the authorized resolution described below. Form must be signed by authorizing clinician (or designee).**

PRINT NAME | TITLE

CENTER/HOSPITAL/PRACITICE

X

PROVIDER SIGNATURE | DATE (MM/DD/YYYY)

## Order Details

**Check any that apply**

- ☐ Specimen mislabeled
- ☐ Requisition has incorrect information
- ☐ Patient billing sheet has incorrect information
- ☐ Specimen & requisition don't match
- ☐ Specimen unlabeled
- ☐ Requisition is incomplete or missing
- ☐ Patient billing sheet is incomplete or missing
- ☐ Specimen is missing

**Description of Discrepancy**

**Authorized Resolution**


 