HOME VISIT REQUEST FORM

Apex Laboratory, Inc.

110 Central Ave.
Farmingdale, NY 11735-6906
Tel: 631-753-3900 Fax:631-753-3910
Toll Free Fax:1-877-521-8482

Nassau, Suffolk, Queens, Brooklyn
FAX: 631-753-3910
Manhattan, S.I., Bronx, Westchester
FAX: 914-963-4709
Order ONLINE via our web based Scheduling system, www.apexlabinc.com (registration required)

THIS ORDER IS FOR A MEDICALLY NECESSARY HOME VISIT (See 1 Below)

☐ Check this box to indicate that the patient is not homebound & should be billed for the home visit (See 2 below)

ORDERING HEALTH CARE PROVIDER / AGENCY

Agency (If Applicable):

Account # (If known):

Provider Last Name: Provider First Name:

Address:

City: State: Zip:

Provider/Agency Phone: ( )

Provider/Agency Fax: ( )

NPI #

PATIENT INFORMATION

Patient SS# or other unique identifier:

Patient Last Name: Patient First Name:

Sex: ☐ Male ☐ Female DOB: / /

Address (where specimen is to be collected):

City: State: Zip:

Patient Home Phone: ( )

Patient Cell Phone: ( )

Alternate Contact:

Alternate Contact Number: ( )

TEST(S) REQUESTED

FASTING: ☐ YES ☐ NO

TEST(S) NAME Please use a valid ICD-10	ICD-10 DIAGNOSIS CODE Please see #3 Below

****WE CANNOT PROCESS ORDERS WITHOUT AN****
****APPROPRIATE DIAGNOSIS. ****

Select Schedule :

☐ One Time Only

☐ Weekly _____ x per week (indicate day(s) below)

☐ Weekly- every _____ weeks (Indicate day below)

☐ Monthly- every ___ month(s)

Start Date _____ End Date _____
(End date required for all standing orders)

REQUIRED

Day(s) of Week: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

STANDING ORDERS CANNOT EXCEED SIX (6) MONTHS

BILLING INFORMATION

PLEASE CHECK (✓) ONLY ONE – Your Primary Insurance Company

☐ MEDICARE # _____

☐ RAILROAD MEDICARE #_____

☐ AARP (Medicare Complete)_____

☐ BILL PATIENT

☐ BILL AGENCY

☐ OTHER INSURANCE NAME_____

OTHER INSURANCE #_____

POLICY HOLDERS NAME: (If not patient)

_____

Patients Relationship to Policy Holder

☐ SELF ☐ SPOUSE ☐ DEPENDENT

IMPORTANT: To find out all insurances accepted please visithttps://www.apexlabinc.com/htdocs/physicians/insurance_and_billing.asp

1) **Medically Necessary Home Visits** – By sending this request, the ordering physician is certifying that the patient is homebound and that both the home visit and the lab test(s) that are being ordered are medically necessary.
2) **Patient Billable Home Visit** – For home visits not deemed as Medically Necessary by the ordering physician, the patient will be responsible to pay for the travel fee. The patient's insurance will be billed for the draw fee and the test(s) performed.
3) **ICD-10 Diagnosis Codes** – Medicare requires a diagnosis for every test ordered and a specific diagnosis for certain tests categorized as "Medicare Limited Coverage Tests". Without an appropriate diagnosis code (a narrative is acceptable), Medicare will not pay for the test(s), and we will not schedule these test(s).