


HOME VISIT REQUEST FORM

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|  <h2 style="margin: 0;">Apex Laboratory, Inc.</h2> <p style="margin: 0;">110 Central Ave. Farmingdale, NY 11735-6906 Tel: 631-753-3900 Fax: 631-753-3910 Toll Free Fax: 1-877-521-8482</p> | | 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) <input type="checkbox"/> Check this box to indicate that the patient is <u>not</u> homebound & should be billed for the home visit (See 2 below) |
| ORDERING HEALTH CARE PROVIDER / AGENCY | | PATIENT INFORMATION | |
| Agency (If Applicable) | | Patient SS# or other unique identifier | |
| Physician Last Name | Physician First Name | Patient Last Name | Patient First Name |
| Address | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | DOB / / |
| City | State | Zip | Address (where specimen is to be collected) |
| Physician/Agency Telephone () | Physician/Agency Fax () | City | State |
| NPI # | | Patient Home Phone () | Patient Cell Phone () |
| TEST(S) REQUESTED | | FASTING: <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| TEST(S) NAME Please use valid ICD-10 Code | ICD-10 Diagnosis Code Please see # 3 Below. | Alternate Contact | |
| | | Alternate Contact Number () | |
| | | BILLING INFORMATION | |
| | | PLEASE CHECK (<input checked="" type="checkbox"/>) <u>ONLY ONE</u> – Your Primary Insurance Company | |
| | | <input type="checkbox"/> MEDICARE # _____ | |
| | | <input type="checkbox"/> RAILROAD MEDICARE # _____ | |
| | | <input type="checkbox"/> GHI MEDICARE # _____ | |
| | | <input type="checkbox"/> AARP (Medicare Complete) _____ | |
| | | <input type="checkbox"/> BILL PATIENT | |
| | | <input type="checkbox"/> BILL AGENCY | |
| | | <input type="checkbox"/> OTHER INSURANCE NAME _____ OTHER INSURANCE # _____ | |
| | | POLICY HOLDERS NAME: (If not patient) _____ | |
| | | Patients Relationship to Policy Holder <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT | |
| | | IMPORTANT: To find out all insurances accepted please visit https://www.apexlabinc.com/htdocs/physicians/insurance_and_billing.asp | |
| **WE CANNOT PROCESS ORDERS WITHOUT AN** **APPROPRIATE DIAGNOSIS.** | | | |
| Select Schedule : <input type="checkbox"/> One Time Only <input type="checkbox"/> Weekly _____ x per week (indicate day(s) below) <input type="checkbox"/> Weekly- every _____ weeks (Indicate day below) <input type="checkbox"/> Monthly- every _____ month(s) Start Date _____ End Date _____ (End date required for all standing orders) Day(s) of Week: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri | | | |
| STANDING ORDERS CAN NOT EXCEED SIX (6) MONTHS | | | |

- 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).