Northwell Labs

New York Metro Division

110 Central Ave
Farmingdale, NY 11735

Mobile Lab Services Request Form

Phone: 631-753-3900
Fax: 631-753-3910
www.MyLabLogix.com

Ordering Provider(s) Information:

Account#:

Physician Group/Healthcare Agency/Facility Name *(if applicable)*:

Physician Last Name: First Name:

Address: *Suite:*

City: State: Zip:

Phone: Fax:

NPI:

CC: Results to additional Doctor/Pharmacy: (Name and Fax#)

Patient Demographics:

Patient MRN if applicable#: DOB: ____/____/____

Patient Last Name: First Name: Sex: Male: ☐ Female: ☐

Address: *Apt:*

City: State: Zip:

Home Phone: *Cell Phone:*

Alternate Contact: (Name and Phone#)

Insurance Information:

☐ **Medicare #:** _____ ☐ **Bill Agency:**

☐ **Other:** ☐ **Bill Patient:**

Plan:

Member ID:

Policy Holder Name and Relationship *(If not Patient):*

Test Information:

Test(s):	*Diagnosis and/or ICD-10 Code*
1	
2	
3	
5	
6	
7	
8	
9	
10	

Misc.:

HELP WITH ICD 10 CODES

- Visit us online at www.MyLabLogix.com
- Click on the "Help with ICD-10 Codes" link
- Search common ICD9- to ICD-10 translations
- Search ICD-10 codes by name
- Find valid ICD-10 codes for Limited Coverage Tests
- LCTs: C+S, HgbA1c, PT/INR, Lipids, Thyroid Studies etc.

Helpful Hints*

- Schedule visits online and view results by logging into your LabLogix Provider Portal account at:
  - **www.MyLabLogix.com**
- To prevent delays in scheduling please remember the following:
  - Be sure that this form is **COMPLETELY** filled out
  - Include Room/Apartment numbers
  - A diagnosis is **REQUIRED** for all requested test(s)
  - Fax orders **no later than 2pm** the day before the visit is needed

Order/Visit Frequency:

One Time Orders

☐ One Time Only On ____/____/_____

Standing Orders

Frequency

☐ Weekly____ x per week ☐ Every Other Week)

☐ Monthly- every ___ month(s) ☐ Other _____

START DATE:

____/____/_____

DURATION (REQUIRED**)**

☐ 1 Month ☐ 3 Months ☐ 6 Months

☐ Other _____

Day(s) of the Week:

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri

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 the patients that are not categorized as homebound, but request a phlebotomist come to their home, Northwell will bill them $27.99 *(subject to change)* for the home visit and charge their insurance carrier for the draw and the test(s). Circle/Check above if the patient is NOT homebound and be billed the home visit.
3. **ICD-10 Diagnosis Codes Required** – Medicare requires a diagnosis for every test ordered and a specific diagnosis for certain tests categorized as "Medicare Limited Coverage Tests". Please provide an appropriate diagnosis code (a narrative is acceptable).

THIS ORDER IS FOR A MEDICALLY NECESSARY HOME VISIT
(See 1 to Left

If this home visit is NOT MEDICALLY NECCESSARY (see 2 to Left

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