

HOME VISIT REQUEST FORM

 <p>Apex Laboratory, Inc. 30 Undercliff Ave. Elmsford, NY 10523-3003 Tel: 914-963-3279 Fax: 914-963-4709 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)
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ORDERING HEALTH CARE PROVIDER / AGENCY	PATIENT INFORMATION
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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 Zip
NPI #		Patient Home Phone ()	Patient Cell Phone ()

TEST(S) REQUESTED	FASTING: <input type="checkbox"/> YES <input type="checkbox"/> NO	Alternate Contact
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TEST(S) NAME Please use valid ICD-10 Code	ICD-10 Diagnosis Code Please see # 3 Below.	Alternate Contact Number ()
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	BILLING INFORMATION
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	PLEASE CHECK (✓) <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 # _____

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

<p>Select Schedule :</p> <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	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
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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).