REQUEST FOR MEDICAL NECESSARY HOME VISIT

FAX TO: (718) 332-2574

By signing below, the physician requesting a home visit by a laboratory phlebotomist is certifying that the patient is homebound (as defined by Medicare) and that both the home visit and the lab tests that are being ordered are medically necessary.

THIS FORM MUST BE COMPLETED IN FULL

QLS CAN NOT PERFORM HOME VISIT UNLESS THE FORM IS COMPLETED IN FULL

[ ] STAT

PLEASE PRINT CLEARLY **DATE OF SERVICE: ____/____/____**

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: ____/____/____ [] M [] F

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT TELEPHONE # (____) _____ - _____

PATIENT MEDICARE # _____

STANDING ORDER:

[] 2X WEEK [] Q1 WEEK(S) [] Q2 WEEK(S) [] Q3 WEEK(S) [] Q1 MONTH(S) [] Q2 MONTH(S) [] Q3 MONTH(S) [] Q4 MONTH(S)

[]	036/037	**PT W/INR & PTT**
[]	20	**CBC, DIFF, PLT**
[]	12	**CMP** (NA, K, CL, GLU, BUN, CR, CA, TP, AB, TBIL, AP, AST, ALT)
[]	11	**BMP** (NA, K, CL,CO2, GLU, BUN, CR, CA)
[]	27	**HEPATIC** (AB, TBIL, DBIL, AP, AST, ALT, TP)
[]	38	**LIPID PANEL** (TRIG, CHOL, HDL, LDLCALC, VLDL CALC, RATIOS, LDL DIR)
[]	SMA18	**SMA18** (CMP,MG,PHOS,URIC ACID,HEPATIC)
[]	119	**GLYCO HGB A1C**
[]	117G	**FBS** (FASTING GLUCOSE)
[]	62	**THYROID 2:** (T4, T3UPTAKE, FTI, TSH, FREE T4, T3)
[]	146	**TSH**
[]	252	**FREE T4**
[]	145	**T3 UPTAKE**
[]	32	**IRON PROFILE** (IRN, TIBC, SAT, FERR)
[]	39	**VITAMIN B12 & FOLATE**
[]	31	**ARTHRITIS** (CBC, ANA, ASO, CRP, RF, ESR, URIC ACID)
[]	2254	**HEPATITIS A,B,C**

[]	196	**PSA**
[]	110	**CPK**
[]	684	**CA 125**
[]	383	**CEA**
[]	1536	**CRP** (HIGH SENS)
[]	300	**CRP** (C-REACTIVE PROTEIN)
[]	677	**HOMOCYSTEINE**
[]	151	**DILANTIN**
[]	148	**DIGOXIN**
[]	995	**VITAMIN D (25 HYDROXY)**
[]	246	**SED RATE (ESR)**
[]	1000	**BNP EVALUATR**
[]	187	**TESTOSTERONE TOTAL**
[]	HPYG	**H. PYLORI AB IGG**
[]	030	**URINALYSIS**
[]	605	**URINE CULTURE & SENSITIVITIES**
[]	212	**MICROALBUMIN URINE**

OTHER TESTS: _____

DIAGNOSIS CODES (ICD-9): _____

Physician Name: _____ **CLIENT #** _____

UPIN # LIC # NPI # _____

Street Address: _____

City: State: Zip: _____ **Physician Telephone #** _____ **Fax #** _____

PHYSICIAN SIGNATURE:* _____ DATE: _____

*This form must be signed and only the referring physician may sign. Original signature is required and SIGNATURE STAMP IS NOT PERMITED.

****48 HOURS NOTICE IS REQUIRED FOR ALL HOUSE VISITS.**