MEDICAL LABORATORY INC.

140 58TH ST., BUILDING A UNIT 3L ● BROOKLYN ●NEW YORK 11220 ●

Tel.:(866)335-DART ● FAX: (718) 934-2003

REQUEST FOR MEDICAL NECESSITY HOME VISIT

FAX TO 718-934-2003

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

THIS FORM MUST BE COMPLETED IN FULL
PLEASE PRINT CLEARLY

PATIENT NAME: _____

INSURANCE: _____

INSURANCE ID: _____

DATE OF BIRTH: _____ *[ ] MALE* *[ ] FEMALE*

ADDRESS: _____ *APT#:* _____

CITY: _____ *STATE:* _____ *ZIP:* _____

PATIENT TELEPHONE# : ___( )_____ - _____

TESTS REQUESTED:

☐ ARTHRITIS (CBC,ANA,ASO,RF,ESR,URIC ACID,ANTI-CCP)	☐ HEPATIC FUNCTION
☐ BMP (SMA 7)	☐ IRON DEFICIENCY (IRON, UIBC,%, SAT, FERR, TRANFERRIN
☐ PRO - BNP	☐ LIPID PROFILE
☐ B12 + FOLATE DEFICIENCY	☐ PSA
☐ CBC, DIFF, PLT	☐ PT / INR
☐ GLYCO Hgb A1c	☐ PTT
☐ CMP (SMA 14)	☐ SED RATE (ESR)
☐ DIGOXIN	☐ THYROID PROFILE (TSH, FREE T4, TUPTAKE)
☐ DILANTIN	☐ URINALYSIS
☐ GLUCOSE (FASTING)	☐ URINE MICROALBUMIN

FASTING: *YES [ ]* *NO [ ]*

STANDING ORDER: *[ ] Q1 WEEK* *[ ] Q2 WEEK* *[ ] Q3 WEEK* *[ ] Q4 WEEK*

OTHER TESTS: _____

ICD-9: _____

PHYSICIAN NAME: _____

TELEPHONE #: ___( )_____-_____ *FAX#:* ____( )_____-_____

PHYSICIAN SIGNATURE: _____ *DATE:* _____

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