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