



**Apex Laboratory, Inc.**  
Home Visit Laboratory Services  
[www.apexlabinc.com](http://www.apexlabinc.com)  
2623 South Seacrest Blvd #206  
Boynton Beach, FL 33435

### Home Visit Request Form

Phone: **561-279-1852**

Fax: **561-279-1853**

#### Patient Demographics:

Patient SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Male:  Female:

#### Ordering Provider(s) Information:

Agency Name: \_\_\_\_\_ Account#: \_\_\_\_\_  
**ACTIVE HOME HEALTHCARE A13502**

Physician Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI: \_\_\_\_\_

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

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:	

**\*\*Helpful Hints from Apex\*\***

- Schedule visits online and view results by logging into your account at:
  - [www.apexlabinc.com](http://www.apexlabinc.com)
- To prevent delays in scheduling please remember the following:
  - Be sure that this form is **COMPLETELY** filled out
  - A diagnosis is **REQUIRED** for all requested test(s)
  - Fax orders **no later than 5pm** the day before the visit is needed
  - Include **DOSE TIME** for all trough levels. Visit will be scheduled prior to dose

**Frequency:**

One Time Only

Weekly \_\_\_\_\_ x Weekly

Bi-Weekly (Every Other Week)

Monthly Every \_\_\_\_\_ Month(s)

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ (Can't exceed 6 months)

\*End date required for standing orders. If end date not indicated, orders will be placed for 6 months. Orders can be cancelled or updated at anytime by contacting Apex.

Fasting?:  Yes  No

Please Note: Fasting should only be ordered if indicated by ordering physician. If patient is not fasting upon arrival, the visit will be rescheduled next day.

Days of Week:  Mon.  Tues.  Wed.  Thurs.  Fri.

- NEED HELP WITH ICD 10 CODES?**
- Visit us online at [www.apexlabinc.com](http://www.apexlabinc.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 (PT/INR, Lipids, Thyroid Studies etc.)

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, Apex Laboratory, Inc. will bill them \$25.00 (subject to change) for the home visit and charge their insurance carrier for the draw and the test(s).

3. **ICD-9/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).

**THIS ORDER IS FOR A MEDICALLY NECESSARY HOME VISIT (See 1 to Right)**

If the home visit is **NOT Medically Necessary**, check this box to indicate that the patient should be billed for the home visit