210 Malapardis Road, Suite 103
Cedar Knolls, NJ 07927
Tel: 973-998-8189
Fax: 973-998-8192

THIS ORDER IS FOR A MEDICALLY NECESSARY HOME DRAW (See # 1 below)

Check ____ this box to indicate that the patient should be billed for the house call (See 2 below)

HOME VISIT REQUEST FORM

PHYSICIAN/AGENCY

Agency (if applicable)		
Physician Last Name	Physicians First Name	
Address		
City	State	Zip
Physicians/Agency Telephone	Physicians/Agency Fax	
NPI		

PATIENT INFORMATION

Patient SS#		
Patient Last Name	Patient First Name	
Gender F M	DOB	
Address		
City	State	Zip
Patient Home Tel	Patient Cell Phone	
Alternate Contact Name	Relation	
Alternate Contact Number		

TEST(S) REQUESTED

FASTING: YES NO

TEST(S) NAME	DIAGNOSIS (See below)

WE WILL NOT PROCESS THIS ORDER WITHOUT AN APPROPIATE DIAGNOSIS CODES

IF THIS SECTION IS NOT COMPLETED, ONLY ONE VISIT WILL BE SCHEDULED

Selecte Schedule:

_______ One time only
_______ Weekly - please circle M T W Th F Sat Sun
_______ Bi-Weekly (every other week)
please circle M T W Th F Sat Sun
_______ Montlhy - every ____ month(s)

Start Date ______________ **End Date** ______________

Additional Information ______________

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 the patients that are not categorized as homebound, but request a phlebotomist come to their home, Fusion Diagnostics Laboratories, LLC will bill them $20.00 (subject to change) for the home visit and charge their insurance carrier for the draw and the test(s).

3) ICD-9 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).

BILLING INFORMATION

PRIMARY INSURANCE INFORMATION

_______ Medicare # ______________

_______ Railroad Medicare # ______________

_______ Bill Patient

_______ Bill Agency

_______ Other Insurance Name ______________

Other Insurance # ______________

Ins Address ______________

Medicaid #

POLICY HOLDERS NAME (if not patient)

DOB ______________ GENDER F M

Patient relation to Policy Holder

SELF SPOUSE DEPENDENT

SECONDARY INSURANCE INFORMATION

Insurance Name ______________

Insurance ID ______________

Ins Address ______________

POLICY HOLDERS NAME (if not patient)

DOB ______________ GENDER F M

Patient relation to Policy Holder

SELF SPOUSE DEPENDENT

***** EVERY ORDER NEEDS PRESCRIPTION ORDER FROM ORDERING PHYSICIAN AND ABN SIGNED FOR MEDICARE PATIENTS *****