UR MEDICINE | Labs

# HOME DRAW APPROVAL FORM

**Directions:** Please complete all information and sign this form.
Fax form to (585) 295-9635

☐ SH Depot

**Please note:** All requests for home draw services require two business days for processing.

***ALL FIELDS ON THIS FORM MUST BE COMPLETED IN ORDER TO PROCESS***

**REQUIRED (PRINT OR PATIENT LABEL)**

Name(Last,First,MI)

Date of Birth | Sex: (circle) M F

Street Address

City, State, Zip

Phone Number

Alternate Phone Number | Client Number

**Indicate primary (1) and secondary (2) insurance**

__Blue Cross/Shield __Child Health Plus __MVP
__Blue Choice __Medicaid __MVPG
__Medicare Blue Choice __Medicare __Aetna
__Other

Doctor: ____________________

Address: ____________________
____________________

Phone: ____________ Fax: ____________

Phone Results to: Fax Results to:

*Special Instructions:*

Fasting Required ☐ 8 Hour ☐ 12 Hour
☐ Patient is on Anticoagulation Therapy

Send Additional Reports To: (Full Name/Address)

**Please complete all information, sign and fax form to (585)295-9635**

Test(s) Requested:

Diagnosis: (ICD-10) ____________________

Frequency: ____________________

Start date of homebound service: ____________________

Expiration date of homebound service: (**Can not exceed 6 months**) ____________________

Date of first draw: ____________________

Compliance is Mandatory and Regulated. For the laboratory to bill property and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-10 code(s) or a descriptive diagnosis must be included on each patient for each test ordered. It is critical that the diagnosis provided to lab is consistent with those recorded in the patient medical record on the date of service.

**Attestation:** My signature below affirms both the information necessary for testing and indicates that the patient above meets the Medicare/Medicaid guidelines that define homebound and is eligible for home draw services under these guidelines. I understand that if at any time this patient no longer meets the Medicare/Medicaid homebound guidelines. I must notify UR Medicine Laboratories to discontinue home draw services.

Physician Signature: ____________________ Date: ____________