HOME DRAW APPROVAL FORM

Directions: Please complete all information and sign this form.
Fax form to (585) 785-4140

☐ 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)785-4140

Test(s) Requested:

Diagnosis:

Frequency: _____

Start date of homebound service: _____

Expiration date of homebound service: _____

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-9 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 URMC Laboratories to discontinue home draw services.

Physician Signature: _____ Date: _____