


LABCORP HOME HEALTH TEST REQUEST FORM

To help you complete the new form, please see the callouts below.

Reminder: Print clearly and enter all information requested. Be sure to transfer information that may be listed on a referral sheet to the test request form.

- 1 Account information preprinted here.
- 2 Specimen identification labels located here. Place one specimen label on each tube. Two patient-specific identifiers (such as name and date of birth) must be included on each label. The identifiers must correspond to information on the patient's test request form.
- 3 Check the fax box and list the fax number(s) where the result report should be faxed. If more than one fax number, please list all numbers here.
- 4 List patient's name here (last, first, middle initial); include patient's gender and date of birth.
- 5 Include collection time and collection date here. This information is critical for certain tests.
- 6 Include NPI
- 7 Include the ordering physician's name (last, first) and physician/authorized signature, if applicable.
- 8 Indicate on the test request form the appropriate ICD-10-CM code(s) at highest level of specificity to identify diagnoses, signs, symptoms, conditions, complaints, or other reason(s) for the laboratory tests ordered for the date of service.
- 9 Complete the patient's insurance information.
- 10 Complete the patient's address information.
- 11 Patient signs and dates here to release information and authorize payment.
- 12 If needed for Medicare, refer to Advance Beneficiary Notice of Noncoverage (ABN) on reverse of form.
- 13 Select the test(s) to be ordered. The tube(s) needed for the home health care collection is printed beside the test number.
- 14 Do not see a test listed? Call **888-522-4452** for assistance regarding test availability and specimen requirements.



HOME HEALTH

To find the nearest patient service center, visit www.labcorp.com or call 888-LABCORP (888-522-2677).

Send additional copy of report to:

Fax Call Mail

Client Number/Physician's Name: 3 Phone/Fax Number: _____

Physician's Address: _____ City, State, Zip: _____

3200.09

1 Patient's Legal Name (Last, First, MI) _____ Sex _____ Date of Birth _____ MO DAY YEAR

2 Specimen Identification Labels (Patient Name, Date of Birth) _____

3 Fax Number(s) _____

4 Patient's Name (Last, First, MI) _____ Sex _____ Date of Birth _____ MO DAY YEAR

5 Collection Time _____ Fasting: Yes No Collection Date _____ MO DAY YEAR Urine hrs/vol _____

6 NPI _____ Physician's ID # _____ Patient's ID # _____ Hospital Patient Status: In-Patient Out-Patient Non-Patient

7 Physician's Name (Last, First) _____ Physician/Authorized Signature _____

8 Diagnosis/Signs/Symptoms in ICD-10-CM format in effect at Date of Service: _____

9 Insurance Information (Primary and Secondary Billing Party) _____

10 Patient's Address _____ City _____ State _____ ZIP _____

11 Patient Signature _____ Date _____

12 Medicare Advance Beneficiary Notice of Noncoverage (ABN) _____

13 Test Selection (Hematology, Chemistry, Microbiology, etc.) _____

14 Additional Tests Special Instructions _____

