Reliable Mobile Labs

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844-487-5227 (844-4UR-LABS)
Order online @ www.reliableml.com/orders

PLEASE INCLUDE:
Copy of Provider's Orders
Copy of Insurance Card
Tests Requested

PATIENT DEMOGRAPHICS

As it appears on Medicare card

Name _____ **Address** _____

_____

Social Security Number _____ **Phone Number** _____

Date of Birth _____ **Gender** _____ **Medicare Number** _____

Other Ins. # _____

PLEASE attach a copy of Medicare & any/all insurance cards (front and back)

PHYSICIAN INFORMATION

Physician Name _____ NPI # _____

Phone Number _____ Fax _____

Exchange number for critical results _____

ASSISTED LIVING FACILITY/HOME HEALTH AGENCY INFORMATION

Name _____

Phone Number _____ Fax _____

COLLECTION SCHEDULE

_____Weekly _____Bi-Weekly _____Fasting req'd

_____Week of ___/___/_____ _____PRN _____

_____Monthly _____One time collection ___/___/___

DIAGNOSIS CODES (ICD 10)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

TEST (S) NEEDED

_____ALT/SGPT	_____Hepatic/Liver panel	_____Valporic Acid (Depakene)
_____AST/SGOT	_____HGB A1C	_____Vitamin B-12
_____BNP	_____Lipid Panel	_____Vitamin D (25 hydroxy)
_____BMP	_____Phenytoin (Dilantin)	_____Uric Acid
_____CRP	_____PSA	_____Urinalysis w/ Reflex to culture
_____CBC w/diff	_____PT/INR	_____Urinalysis w/ Culture
_____CK,total	_____Sed Rate (ESR)	Urine Culture Only
_____CMP	_____TIBC	
_____Glucose	_____T3, free	
_____Ferritin	_____T4, free	
_____Folate	_____TSH	

Additional Test(s)

The above patient meets CMS guidelines to be homebound.

_____ _____

Provider Signature Date