

Signature requirements for laboratory orders or requisitions

This communication applies to the Medicaid and Medicare Advantage programs for Healthy Blue.

Healthy Blue strives to ensure our providers understand documentation compliance, and we are committed to educating our providers in hopes of eliminating errors in documentation practices. It is a best practice and industry standard that physicians sign and date laboratory orders or requisitions.

Although the provider signature is not required on laboratory requisitions, if signed and dated, the requisition will serve as acceptable documentation of a physician order for the testing and so it is strongly encouraged. In the absence of a signed requisition, documentation of your intent to order each laboratory test must be included in the patient's medical record and available to Healthy Blue upon request. Documentation must accurately describe the individual tests ordered; it is not sufficient to state "labs ordered."

Healthy Blue will consider laboratory order or requisition requirements met with one of the following:

- A signed order or requisition listing the specific test(s)
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record supporting the physician's intent to order the test(s)
- An authenticated medical record (for example, office notes or progress notes) supporting the physician's intent to order the specific test(s)

Attestation statements are not acceptable for unsigned physician order or requisitions. Signature stamps are not acceptable.

References:

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf>
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#BloodCount>
- *Title 42 CFR §410.32*
- *Documentation Standards for Episodes of Care – Professional Administrative*

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