WELLNESS FIRST
A Division of BHS

Biometric Reporting Form for

AMGH Collection Site Screening

COLLECTION SITE INSTRUCTIONS FOR:

Firelands Corporate Health
5420 Milan Road, Sandusky, OH 44870
(419) 557-5550 / Mon-Fri: 7:00am-5:00pm

1. Please call 419-557-5052 to schedule your appointment for venipuncture lab draw for lipid panel with glucose and body measurements (height, weight, waist circumference and blood pressure).
2. Take this form and the LabCorp form with you. This provides the information the clinic needs, including billing details.
3. **Print the date, your name, date of birth, and employee ID # on this page. Print name, date of birth, sex, patient ID # (Your EMPLOYEE ID), complete mailing address and phone number on the LabCorp form.**

First Name

Last Name

Date of Birth

Employee ID (REQUIRED)

Clinic Instructions:

1. Please make sure member included name and employee number (as Patient ID) on LabCorp form.
2. Record body measurements.
3. Package specimen and send to LabCorp.
4. Invoice: ******PLEASE NOTE CHANGE IN THE BILLING ADDRESS******

Wellness First
P. O. Box 830724
Birmingham, AL 35283

5. **Please fax form to Wellness First at 205-879-1178 or email to wellness@behavioralhealthsystems.com.**

Date

Height (Inches)

Weight (Lbs.)

Blood Pressure

Waist Circumference

REQUESTED BY

LabCorp
Laboratory Corporation of America

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

☐ Fax
☐ Call
☐ Mail

Send additional copy of report to:
Client Number/Physician's Name
( ) Phone/Fax Number
Physician's Address
City, State, Zip

0702.21

BHS/AMGH
LABCORP WELLNESS VERIFIED
2 Metroplex Drive, Suite 500
Birmingham, AL 35209
205-879-1150

PLEASE NOTE: This is a PAPER Requisition. It needs to be entered into the system manually.

Please use EMPLOYEE COMPANY ID # for the Patient's ID #.

*****ENTER ONLY THE ACCOUNT NUMBER CIRCLED*****
LABCORP ACCOUNT NUMBER: 01385590

CIRCLE ONE:

1841315298-
Szabo, Cheryl

CHECK ONE:

03 [✓] ACCOUNT BILL

Patient's Legal Name (Last, First, MI) | Sex | Date of Birth MO DAY YR | Collection Time : AM PM | Fasting ☐ Yes ☐ No | Collection Date MO DAY YR | Urine hrs/vol hrs_____ vol_____

NPI | UPIN | Physician's ID # | Patient's SS # | Patient's ID #

Physician's Name (Last, First) | Physician/Authorized Signature X_____

Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service
Highest Specificity Required

PATIENT
Patient's Address | Phone
City | State | ZIP

RESP. PARTY
Name of Policy Holder (if different from patient)
Address of Policy Holder | APT #
City | State | ZIP

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X
Patient's Signature | Date

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
Insurance Carrier *	Insurance Carrier *
ID #	ID #
Group #	Group #
Insurance Address	Insurance Address
Name of Insured Person	Name of Insured Person
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name

*If Medicaid State | Physician's Provider # | Workers Comp ☐ Yes ☐ No

MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Refer to Determining Necessity of ABN Completion on reverse.

TRAVEL LOG ID

PST HR# | DATE | LOG#

PLEASE PRINT

[✓] **303756 Lipid Panel**

[✓] **001032 Glucose, Serum**

[✓] **101300 Biometrics**

ITEM # 00000000000053663 FORM # 0702 (UNIVERSAL FREEFORM 07)

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(REV 06/25/2015)

ORIGINAL-LABORATORY / COPY-CLIENT

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. LISTED ABOVE ARE THE CUSTOMIZED PROFILES YOU HAVE SPECIFICALLY REQUESTED FROM LABCORP. THE INDIVIDUAL COMPONENTS HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY IN THE SPACE ABOVE. COMPONENTS AND BILLING CODES FOR NON CUSTOMIZED TEST PROFILES ARE LISTED ON REVERSE. COMPONENTS MAY BE BILLED SEPARATELY IN ACCORDANCE WITH CARRIER POLICIES.

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my health care providers, Wellness First and University Services staff and laboratories that run medical tests for me to use and disclose certain protected health information about me.

The protected health information will be used or disclosed for the sole purpose of complying with state and federal laws. These laws authorize a review and approve laboratory requisitions and review laboratory results.

I authorization my protected health information and laboratory test results to be mailed through the United States Postal Service in order for me, the patient , to receive results to allow me to make informed decisions about my health care.

I understand that I have to receive a copy of this authorization. I understand that I will not be able to receive laboratory testing unless I sign this authorization. I understand I have the right to refuse to sign this authorization. I understand that by signing this authorization I may not be continued to be protected under the HIPPA Privacy Rule. This authorization will expire one year after the date of this authorization.

I understand that this authorization is for my consent to participate in the AMGH Wellness performed by Wellness First and the parties listed above. I have received a copy of this authorization and consent to its terms and representations.

Name:

Signature:

Date:

This signed and dated authorization form must accompany your physician form and lab forms