

COLLECTION SITE INSTRUCTIONS FOR:

**St. Luke's Work Well Clinic**

830 1st Ave NE, Cedar Rapids, IA 52402  
(319) 369-7173 / Mon-Fri: 7am-5pm

1. Please call (319) 369-7173 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

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Last Name

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Date of Birth

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Employee ID (REQUIRED)

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**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](mailto:wellness@behavioralhealthsystems.com).

Date

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Height (Inches)

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Weight (Lbs.)

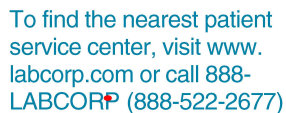
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Blood Pressure

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Waist  
Circumference

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

☐ Fax      Send additional copy of report to: \_\_\_\_\_  
☐ Call      Client Number/Physician's Name \_\_\_\_\_ Phone/Fax Number \_\_\_\_\_  
☐ Mail      Physician's Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

\*\*\*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 MO DAY YR	Date of Birth MO DAY YR	Collection Time AM PM	Fasting <input type="checkbox"/> Yes <input type="checkbox"/> 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 <div style="border-bottom: 1px solid black; height: 20px;"></div>		Hospital Patient Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient			
<b>Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service</b> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>									
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 <input type="checkbox"/> Yes <input type="checkbox"/> No				

**PATIENT**

Patient's Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**PATIENT**

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 \_\_\_\_\_

**MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**  
Refer to Determining Necessity of ABN Completion on reverse.

**TRAVEL LOG ID**

**MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

Refer to Determining Necessity of ABN Completion on reverse.

TRAVEL LOG ID

PST HR#

DATE \_\_\_\_\_

LOG#

☒ 303756 Lipid Panel

☒ 001032 Glucose, Serum

**X101300XBiometrics**

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[REV 06/25/2015]

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.

ORIGINAL-LABORATORY / COPY-CLIENT

## **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 authorize 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