

TO: Health Screening Participant

FROM: **Interactive Health**

DATE: January 1, 2019 - July 31, 2019

RE: **INSTRUCTIONS** for Health & Wellness Screening Voucher Service

**Please Read Carefully**

This information is regarding the Screening Voucher Service for your biometric screening, which is covered as a wellness benefit by Ascend to Wholeness. The screening will provide information about your current health status and help you to identify potential health risks and opportunities for improvement.

To assist you in obtaining your free screening, we have outlined the steps for you as follows:

**Step 1: BEFORE YOUR APPOINTMENT:** Complete the Consent Form (Page 2) and return it to Interactive Health by Fax, 410-356-6205, email, [offsiteforms@interactivehealthinc.com](mailto:offsiteforms@interactivehealthinc.com), or US Mail, 11409 Cronhill Dr, Suite M, Owings Mills, MD 21117. **Please note: Complete your current measurements for Blood Pressure, Height, and Weight and include them on the Consent Form. These will not be measured by LabCorp.**

**Step 2:** To find a LabCorp in your area you can use your local telephone book or visit [www.labcorp.com](http://www.labcorp.com). To use the website, on the home page in the "Labs & Appointments" box enter your address or ZIP code. Click your address or ZIP code from the Matching Places or Matching ZIP Codes that appear below the box. Make sure "Routine labwork" is selected from the "Select Service" drop down and click the blue "GO" button. The site search results will provide details on the hours of operation, phone numbers, and the ability to make appointments for each LabCorp location.

**Step 3: You must take the completed Requisition Form (Page 3) with you to LabCorp.**

**Step 4: FASTING IS REQUIRED FOR THIS TEST (8 HOURS = ONLY WATER AND MEDICATIONS). THIS TEST IS A VENIPUNCTURE NOT A FINGERSTICK.**

**Step 5:** Your lab results will be sent to Interactive Health. Your results will be mailed to you to the address you provided.

Your results are confidential and will not be shared with your employer. In order to help your employer determine the success of this program, aggregate data will be provided to Ascend to Wholeness.

**Note: Your LabCorp Requisition Voucher has an expiration date.  
Please note the expiration date stamped on the bottom of your form.  
This voucher will expire and no longer be valid if not used before the expiration date.**

**Interactive Health, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117  
Phone: 800-711-8656 Fax: 410-356-6205**

**Return this form by ONE of three methods: Mail: Interactive Health, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117, Email: [offsiteforms@interactivehealthinc.com](mailto:offsiteforms@interactivehealthinc.com), FAX: 410-356-6205**

LabCorp®

Health Solutions: Ascend to Wholeness  
LABCORP WELLNESS VERIFIED  
11409 Cronhill Drive, Suite M  
OWINGS MILLS, MD 21117  
866-827-8046

\*\*ENTER ONLY THE ACCOUNT NUMBER CIRCLED\*\*

Significant Clinical Information

Fasting

Non-Fasting

CUSTOMIZED  
REQUEST

(EMBOSSING AREA)



7040.25

Account No. 19595245

Submit Separate Specimens (Not Request Forms) for each Frozen Test Requested.

Specimen Date Mo Day Yr	Specimen Time Hr Min	Patient Name (Last)	(First, MI)	Sex	Date of Birth Mo Day Yr	Age Yrs Mos
Patient I.D. #		Physician I.D.		Patient/Resp. Party's Phone #		
Responsible Party or Insured's Name (Last, First)		Patient's SS #				
Address		City		State		Zip Code
Patient's Signature		Date				
Resp. Party's Employer		Medicaid Number/HMO #		Medicare #		
Physician Name		NPI #	UPIN #	Physician's Signature		Provider #
Diagnosis Code (ICD-9)		Insurance Code or Company Name and Address			Insurance I.D. #	
Group # or Name		Relationship to Insured (Circle One) 1-Self 2-Spouse 3-Other		Urine Total 24hr. Vol. _____		Patient's Ht. _____ Wt. _____

CHECK ONE:  
03 [X] ACCOUNT BILL

CIRCLE ONE:  
Dr Barry W Berger  
1770634560

MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)

Use a separate ABN when ordering tests which require an ABN. Refer to the back of this form for more information.

- @ = Subject to Medicare medical necessity guidelines
- % = Subject to Medicare frequency guidelines
- # = Medicare deems investigational

INDIVIDUAL COMPONENTS OF TEST COMBINATIONS / PROFILES LISTED IN THE SECTION ABOVE CAN BE ORDERED BELOW

STAT	VENIPUNCTURE	NON LABCORP	VERBAL ORDER	CHART ORDER	HANDWRITTEN	24 HR TUV	PST/PSC #
<input type="checkbox"/> 998074	<input type="checkbox"/> 998085	<input type="checkbox"/> 998239	<input type="checkbox"/> 998250	<input type="checkbox"/> 998261	<input type="checkbox"/> 998272	<input type="checkbox"/> 998283	

TRAVEL LOG ID

PST HR# DATE LOG#

[ X ] 303544 LP + Glucose

EXPIRES 7/31/2019

GEL SPUN	USST UNSPUN	SER SERUM TRNSPT	FRZ FRZ TRNS	RED RED	LAV LAVENDER	SLD SLIDE	BLU LT. BLUE	GRY GREY	GRN GREEN	RYB RYL BLU	YEL ACD	PLS PLASMA	URN URINE	24U 24 HR URINE	TA-U TART. ACID	FL FLUID	OT OTHER	BACT BACT TRNSPT	O & P KIT	PROBE PROBE TRNSPT	URN CUL URN CUL TRNSPT	STERIL STERIL TRNSPT	FECAL FECAL TRNSPT	VIRAL VIRAL TRNSPT
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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. COMPONENTS OF THE ORGAN OR DISEASE PANELS AND COMMON TEST COMBINATIONS ARE SHOWN ON THE REVERSE SIDE, AND ANY COMPONENT MAY BE ORDERED INDIVIDUALLY. COMPONENTS MAY BE BILLED SEPARATELY PER CARRIER POLICY. THE INDIVIDUAL COMPONENTS OF ANY CUSTOMIZED PROFILES HAVE BEEN DISCLOSED TO YOU AND THEY MAY ALSO BE ORDERED INDIVIDUALLY.