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,410-356-62 05, email, offsiteforms@interactivehealthinc.com, or US Mail, 11409 Cronhill Dr, Suite M, OwingsMill s, MD 21117. 3OHDVHQRWH ***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. 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 blood work" 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

Page 2 - Consent Form

Health and Wellness Screening Voucher Service

Release of Liability Informed Consent Form

I, the undersigned, represent that my participation in this Biometric Health Screening is voluntary. My individually identifiable health information will not be shared with my employer; however my employer may be advised of the fact of my participation. I understand my individually identifiable information may be shared with and used by my employer-sponsored group health plan to provide care management services, and/or data aggregation for improvement purposes. Such information will not be used for any other purposes. The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

I, the undersigned, hereby consent to the collection of a blood sample for the purpose of measuring my cholesterol and glucose levels. I hereby release Health Solutions Services Inc., a subsidiary of Interactive Health Solutions, Inc., my employer, LabCorp, and any other organization(s) associated with this screening, their affiliates, directors, officers, employees, successors and assigns, from any liability arising from or in any way connected with my participation in any of these tests or from the data derived there from. I understand that:

1. The data derived from the test(s) are considered to be preliminary; they are screening assessments only. They do not constitute a diagnosis of hypercholesterolemia, pre-diabetes or diabetes.

2. The responsibility for initiating a follow-up examination to confirm the results of this screening and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with this screening.

3. I agree to have only the "selected" screenings completed on the requisition form.

Last Name **First Name**

Member ID# **'E' for employee or 'S' for spouse of Plan Member**

Birth date **Gender M/F**

Street Address

City **State**

Zip Code **Email Address (Please Print)**

Home or Cell Phone (no spaces) **Work Phone (no spaces)**

My Height Is: _____ Ft ___ Inches My Weight:______ Blood Pressure: Systolic——— Diastolic ———

Signature: ___________________________________ Date: ——— / ——/ 20____

Return this form by <u>ONE</u> of three methods: <u>Mail</u>: Interactive Health, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117, <u>Email</u>: offsiteforms@interactivehealthinc.com, <u>FAX</u>: 410-356-6205

Job: 1372240 FSep: Black PANTONE 186 C

Page 3 - Requisition Form

REQUESTED BY

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

1372240

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

Account No. **19595245**

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 #
I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION RELATED TO THE SERVICES DESCRIBED HEREIN AND AUTHORIZE PAYMENT DIRECTED TO LABCORP. I AGREE TO ASSUME RESPONSIBILITY FOR PAYMENT OF CHARGES FOR LABORATORY SERVICES THAT ARE NOT COVERED BY MY HEALTHCARE INSURER.	Responsible Party or Insured's Name (Last, First)		Patient's SS #
Patient's Signature Date	Address	City	State Zip Code
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. #	Workers Comp. Yes No
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**

PLEASE PRINT

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

LABCORP USE ONLY

STAT	VENIPUNCTURE	NON LABCORP	VERBAL ORDER	CHART ORDER	HANDWRITTEN	24 HR TUV	PST/PSC #
☐ 998074	☐ 998085	☐ 998239	☐ 998250	☐ 998261	☐ 998272	☐ 998283	

TRAVEL LOG ID

PST HR# DATE LOG#

[X] 303544 LP + Glucose

EXPIRES 7/31/2019

ITEM # 000000000000002684 FORM # 7040.25 (NORTH CAROLINA) (CARRIER: CIGNA)

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(REV 01/005/07)

ORIGINAL-LABORATORY / COPY-LABORATORY / COPY-CLIENT

Created: Tuesday, January 09 2007 13:10:56 ESTRun: Tue Jan 9 13:21:58 2007

CONTAINERS RECEIVED

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 TRNSPT	O & P KIT	PROBE TRNSPT	URN CUL TRNSPT	STERIL TRNSPT	FECAL TRNSPT	VIRAL TRNSPT

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.