

LabCorp Instructions for Offsite Participation

Thank you for taking the time to participate in Hospice of the Piedmont's wellness program. It was designed to help you see how your lifestyle affects your health and often serves as a motivator for behavior change. Below are the instructions for completing your screening via LabCorp. During the screening process you will complete a venous blood draw, blood pressure reading, and height and weight measurement. You will also need the LabCorp Voucher form, which you are required to take to your nearest patient care center for completion.

If you would like to participate in the biometric screenings by using the LabCorp Voucher option, please follow the instructions below. ***You must take the attached LabCorp Voucher form to your appointment at the nearest patient care center for completion.***

1. Complete the Paper Health Questionnaire:
Participants must complete and email the paper Health Questionnaire to data@healthdesigns.net. Please complete all 15 questions on the form, including first name, last name and date of birth.
2. Visit your nearest LabCorp patient care center to complete your health screening:
 - Print the LabCorp voucher after you complete your health assessment. Fill in your name, sex, and DOB. The other fields will be completed by LabCorp staff.
 - To locate a LabCorp patient care center offering biometric screenings, visit www.LabCorp.com and click "Find a Lab".
 - Enter your address and select Employee Wellness with body measurement in the "Service" section and then click "Find a Lab".
 - Select the location and click "Make Appointment" to choose the appointment time that works best for you before **September 30, 2026**.
 - Select "I have already paid or someone else is responsible" on the Billing tab.
 - Then Submit your request.
 - **Please bring the voucher and Driver's License with you to your appointment.**
***Fasting is recommended for 9-12 hours. Be sure to drink plenty of water and take medications as prescribed by your healthcare provider.*

LabCorp will send your information directly to our office for processing.

3. A health coach from Health Designs will reach out by email to schedule your **telephonic coaching session**. During this call, they'll review your screening results, answer any questions you have, and **discuss your unique health and wellness goals**. If you miss the call or have questions, email virtualcoach@healthdesigns.net.

To learn if we have received your paperwork and/or confirm the data we have recorded for you, you may contact Health Designs after the first business day of the next month at: 904-285-2014 or data@healthdesigns.net.

***Please note – we are only able to discuss this personal health information directly with the participant, in accordance with HIPAA and other privacy regulations.**



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

Send additional copy of report to:
 Fax
 Call Client Number/Physician's Name _____ Phone/Fax Number _____ 0703.33

HOSPICE OF THE PIEDMONT C/O HEALTH DESIGNS
 LABCORP WELLNESS VERIFIED
 135 PROFESSIONAL DRIVE STE 104
 PONTE VEDRA BEACH, FL 32082
 904-285-2019

ENTER ONLY THE ACCOUNT NUMBER CIRCLED
LABCORP ACCOUNT NUMBER: 09026805

CIRCLE ONE:

1346249315 - HUMPHRIES, STEFAN G

CHECK ONE:
 ACCOUNT BILL

Patient's Legal Name (Last, First, MI)		Sex	Date of Birth MO DAY YR			Collection Time AM <input type="checkbox"/> Yes PM <input type="checkbox"/> No	Fasting <input type="checkbox"/> Yes <input type="checkbox"/> No	Collection Date MO DAY YR			Urine hrs/vol hrs ____ vol ____
NPI	Physician's ID #	Patient's ID #		Hospital Patient Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient							
Physician's Name (Last, First)		Physician/Authorized Signature X _____									
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service Highest Specificity REQUIRED											
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
RESP. PARTY

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 _____ Date _____

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

LABCORP USE ONLY	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	

- 101300 Biometrics
- 262204 LP+Glu
- 379559 LP+Glu

PLEASE PRINT

PLEASE PRINT

ORIGINAL-LABORATORY / COPY-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.