REQUESTED BY

1A 1B 1C

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

0702.14

Lehigh c/o Aduro
LabCorp Wellness Verified
16700 NE 79th Street, Suite 204
Redmond WA 98052
866-906-2433

LABCORP ACCOUNT NUMBER: **46900365**

CIRCLE ONE:

1881691822 - Ted Steffan

CHECK ONE:
03 [X] ACCOUNT BILL

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

NPI	UPIN	Physician's ID #	Patient's SS #	Patient's ID #
N/A	N/A	N/A	N/A	N/A

Physician's Name (Last, First): N/A
Physician/Authorized Signature: X N/A

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

Diagnosis/Signs/Symptom in ICD-9-CM Format (Highest Specificity)
N/A REQUIRED

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

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

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

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

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)
N/A Refer to Determining Necessity of ABN Completion on reverse.

TRAVEL LOG ID

N/A	N/A	N/A
PST HR#	DATE	LOG#

PLEASE PRINT

PLEASE PRINT

[X] 262204 LP+Glu

[X] 005009 CBC With Differential/Platelet

[ ] 081950 Vitamin D, 25-Hydroxy

[ ] 010322 Prostrate-Specific Ag, Serum

[ ] 004259 TSH

ITEM # 0000000000000053663 FORM # 0702 (UNIVERSAL FREEFORM 07)

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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. 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.