



OPTION 2: LAB VOUCHER + PROOF OF VISIT

1. Follow the [LabCorp Voucher Program](#) instructions (page 2) to complete the required bloodwork through LabCorp using the lab voucher (page 3) by May 31. Your biometric results will automatically be sent to Wellworks For You when using the voucher.
2. Schedule your **routine preventive physical** with your primary care provider (PCP). Take the Proof of Visit form (page 4) to your appointment to be signed by your PCP. Submit the form to Wellworks For You by May 31.



LABCORP VOUCHER PROGRAM

Sign up for an Appointment

Visit a local LabCorp facility to complete your screening with lab work. It is highly recommended that you schedule an appointment before you go. Please follow the instructions below to schedule your appointment at a local LabCorp facility.

Make an appointment via phone:

- Call **1-888-522-2677** to schedule an appointment via phone

Make an appointment online:

1. Visit LabCorp online at www.labcorp.com
2. Click on **Find a Lab**
3. Enter your **Zip Code** to access a list of local labs
4. Select **Schedule an Appointment** under the lab of your choice
 - Reason for Testing – **Employee Wellness with Body Measurement**
 - Will you be fasting – **Yes**
 - Select a date and time
 - Click **Continue** and finalize your appointment

What to Bring to Your Appointment

1. Please bring the **Lab Voucher** which is attached on page 2 of this document. **Your Lab Voucher must be completed prior to your appointment and include your Full Name, Sex, and Date of Birth. If you would like your results sent directly to your primary care provider, please fill out the physician section in the top right corner of the lab voucher.**
2. Valid government Photo ID*

*It is very important that you bring these two items with you when you arrive at LabCorp. If you arrive to your appointment with a blank voucher and the required information not filled in, you may be turned away and unable to complete your screening. Please **fast** (do not eat) for nine (9) hours prior to your appointment. Please drink **PLENTY OF WATER** and continue to take any prescription medications. *If you are diabetic, please consult your physician before fasting.*

Please Note: LabCorp will send Wellworks For You the results of your screening directly. Please allow two (2) weeks for your results to be uploaded into the Wellworks Wellness Portal. You can view your progress towards participating in the Wellness Program under My Next Steps on your Wellness Portal homepage.

Patient Service Center Initiatives Launched to Protect Communities

To ensure the health of their patients, employees and the broader community, LabCorp has taken a number of steps in response to the Coronavirus (COVID-19) outbreak to follow CDC Guidelines, including social distancing and increased sanitation at nearly 2,000 patient service centers across the United States. To view additional information on what LabCorp is doing to ensure the health and safety of their patients please visit their website at www.labcorp.com.



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

Bancroft c/o Wellworks For You
LABCORP WELLNESS VERIFIED
 70 E. Lancaster Ave. Frazer PA 19355
 800-425-4657

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

*****ENTER ONLY THE ACCOUNT NUMBER CIRCLED*****
LABCORP ACCOUNT NUMBER: 37015615

CIRCLE ONE:

1174675565 - KROPP, DENNIS

CHECK ONE:

03 [✓] ACCOUNT BILL

Patient's Legal Name (Last, First, MI)		Sex	Date of Birth			Collection Time	Fasting	Collection Date			Urine hrs/vol
			MO	DAY	YR	AM PM	<input type="checkbox"/> Yes <input type="checkbox"/> No	MO	DAY	YR	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			Patient's Address			Phone			
		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

City State ZIP

Name of Policy Holder (if different from patient)

Address of Policy Holder APT #

City State ZIP

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.

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

PLEASE PRINT

PLEASE PRINT

ORIGINAL-LABORATORY / COPY-LABORATORY / COPY-CLIENT

ANNUAL PHYSICAL PROOF OF VISIT FORM

Take this form with you to your scheduled doctor's visit to be completed and signed by the attending physician. It is the participant's responsibility to submit the Annual Physical Proof of Visit Form as part of the wellness program to be returned to Wellworks For You as outlined below, by **May 31 of the Wellness Year**.

PATIENT CONTACT INFORMATION

COMPANY NAME: _____

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ MALE FEMALE

PHONE: _____ EMAIL: _____

PHYSICIAN INFORMATION

PHYSICIAN OFFICE/NAME: _____

OFFICE PHONE/ADDRESS: _____

This **Annual Physical Proof of Visit Form** confirms that the patient named above received the following preventive care between **June 1 and May 31 of the Wellness Year**.

GENERAL

- Annual Preventive Exam**
(physical performed by Primary Care Physician)

Physician

I certify that the patient listed above received the tests indicated on this form on: ____/____/____

Physician Signature: _____ Date Signed: _____

SUBMIT YOUR COMPLETED FORMS BY MAY 31 OF THE WELLNESS YEAR

All forms should be submitted to the Wellworks Forms Department. Submit your completed forms in one (1) of the following ways.

- **Upload to Portal:** Click the **Upload a Form** tile from the homepage or via the menu page, select the event title from the dropdown and upload your form to the portal. This will be securely emailed for processing. Users are limited to **one (1)** file per email.
- **Upload to Mobile App:** Take a photo of your form using your Smartphone, and upload it to the Wellworks For You Mobile App via the **Contact Us/Send a Form** tab.

PLEASE NOTE: Wellworks For You requires at least **seven (7) to ten (10)** business days for processing and participation to be updated in the Wellness Portal.