LABCORP WEB COC
COLLECTION AUTHORIZATION FORM

Donor Name -

Please present this authorization form to the collection site upon arrival.

COLLECTOR
***** Account Name: HQRC MANAGEMENT SERVICES**
***** LabCorp Account - 950930-NON-DOT**
*** Test(s) To Be Performed – 10 PANEL**

***** REQUIRED FIELDS**

- **REASON FOR TEST:** ☒ **PRE-EMPLOYMENT** ☐ **RANDOM**
- ☐**REASONABLE SUSPICION/FOR CAUSE** ☐**POST ACCIDENT**
- ☐**PERIODIC** ☐**OTHER**

Collection Site Location (optional):

Collection site name
Street Address
City, State Zip
Phone

Collector-If you have any questions, please contact:

Client Contact **DANASIA WARDLOW**
Phone # 845-369-3703

OR
OTS Customer Operations: 1 800 833-3984 option #5
LabCorp Web COC Authorization Form Revised: 10/25/2009

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

HQRC Management Services
LABCORP WELLNESS VERIFIED
29 North Airmont Road
SUFFERN NY 10901-
(845) 369-3709

☐ Fax ☐ Call ☐ Mail — Send additional copy of report to: Client Number/Physician's Name; Phone/Fax Number ( ); Physician's Address; City, State, Zip

0703.21

*****ENTER ONLY THE ACCOUNT NUMBER CIRCLED*****
LABCORP ACCOUNT NUMBER: 31027855

CIRCLE ONE:
1538279625-
JACOBSON, BARRY

CHECK ONE:
03 [X] ACCOUNT BILL

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

NPI | Physician's ID # | Patient's ID # | Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ 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

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

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

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 ☐ 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)
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 #
☐ 998074	☐ 998085	☐ 998239	☐ 998250	☐ 998261	☐ 998272	☐ 998283	

PLEASE PRINT

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[ ] 006395 Hep B Surface Ab

[ ] 058495 Measles/Mumps/Rubella Immunity

[X] 182873 QuantiFERON TB Gold (In Tube)

[ ] 096206 Varicella-Zoster V Ab, IgG

ORIGINAL-LABORATORY / COPY-LABORATORY / COPY-CLIENT

ITEM # 056509 FORM # 0703 (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.