Lannett

2017 PASSPORT TO HEALTH™ BIOMETRIC VOUCHER

Thank you for participating in the PASSPORT to HEALTH™ wellness program, sponsored by Lannett Company, Inc. & Attentive Health LLC. Enclosed you will find a voucher to complete your biometric screening at a LabCorp location near you. Please review the following instructions carefully.

Biometric Screening Deadline

To use this voucher, please schedule your screening between July 22 and August 5, 2017.

LabCorp Voucher Instructions

Enclosed you will find detailed instructions about how to make an appointment and how to fill out your voucher. Please review these instructions carefully and **BRING YOUR VOUCHER WITH YOU** to your appointment at a LabCorp location.

Questions?

If you have any questions, please contact Attentive Health at 877.269.9754. If you would prefer to get your biometric screening at your primary health care provider, please contact Attentive Health to request a Physician's Form.

Frequently Asked Questions

Can I eat prior to my health screening?

No. Fasting is required for this health screening. You should ***drink plenty of water*** during the 24-48 hours leading up to the event and ***eat or drink nothing other than water for at least 8 hours prior*** to your appointment time (10-12 hours is preferred).

Will my health information be held confidential?

Yes. By law, Attentive Health must protect your privacy in these matters and will hold all information confidential. No individual information will be disclosed without your written permission. Attentive Health will prepare a company-wide group aggregate report illustrating the top health risk categories, but no personal information will be contained in that report.

Are the results accurate?

LabCorp adheres to the most stringent guidelines for quality control and assurance. The technology behind the testing performed is very accurate with a minimal margin of error.

I don't like to have blood drawn. Will this test hurt?

No. While some people are a little more apprehensive to have a full venipuncture blood draw, they usually find it can actually be less painful than the finger-prick technology. The key is to ***drink plenty of water*** and stay as relaxed as possible. The phlebotomists who will be drawing your blood understand the apprehension participants have and will be careful and compassionate in their service.

LABCORP VOUCHER INSTRUCTIONS

FOR PARTICIPANT USE ONLY

This voucher can ONLY be used from July 22 – August 5, 2017.

Thank you for participating in the **Lannett** screening program. As part of the program, participants who are not able to attend the onsite health screening can receive a free screening at a LabCorp facility. The screening will consist of a venipuncture blood draw for cholesterol and blood glucose.

STEP 1: FIND A FACILITY

Vouchers are redeemable only at LabCorp facilities. You will not be allowed to have the screening test without the voucher. Expect the screening to take approximately 15 – 20 minutes. To locate the nearest facility and schedule an appointment, visit www.labcorp.com/findalab. Enter your home city and/or zip and select "**Routine Phlebotomy**" from the service options to search for the nearest locations. On the next page, select "Schedule an Appointment" at your preferred clinic. Fill in your appointment details, selecting "**Labwork (Routine Clinical)"** as your reason for testing. Appointments are encouraged, although walk-ins are accepted on a first come, first serve basis.

STEP 2: COMPLETE VOUCHER FORM

On the attached voucher, fill in the following **required** information (first and last name, sex, date of birth, time, fasting ["**Yes**" if you have NOT eaten nor had anything other than water to drink in the past 8+ hours), date, address, and phone number], indicated by the un-shaded area below. **YOUR PATIENT ID IS THE FIRST FOUR LETTERS OF YOUR LAST NAME PLUS THE LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER (i.e. ABCD1234).** All other information can be left blank. **YOU MUST TAKE THE VOUCHER TO THE LAB WITH YOU IN ORDER TO RECEIVE A SCREENING.**

RESULTS

You will receive a hard copy of your results in the mail. If you have not received your results within four weeks of your screening, please contact support@wellnesscorporatesolutions.com.

CONSENT: I understand that the purpose of my health screening is to help evaluate my health status and any potential health risks. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks. I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs or for industry research. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. By using this voucher, I acknowledge that it is my sole responsibility to: (a) contact support@wellnesscorporatesolutions.com if I have not received my test results within 4 weeks of my screening and (b) follow-up with my physician to discuss my test results. I hereby release and forever discharge Wellness Corporate Solutions, LLC, and its affiliates, and each of their respective owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

FOR LABCORP USE ONLY

- If you have any questions about using the voucher, please call LabCorp at 800-833-3934.
- Fasting is not required by this client. Do not turn anyone away for not fasting. Please mark Fasting or Non-Fasting.
- If you are unable to locate the account number in your LCM, please contact your Supervisor for assistance.
- **Only screen for tests indicated on the LabCorp voucher. DON'T ask participant which tests they want to receive.**

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)

Lannett c/o Wellness Corporate Solutions
LABCORP WELLNESS VERIFIED
7617 Arlington Road
Bethesda MD 20814
866-827-8046

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

0702.21

ENTER ONLY THE ACCOUNT NUMBER CIRCLED
LABCORP ACCOUNT NUMBER: 19255395

CHECK ONE:
03 [X] ACCOUNT BILL

CIRCLE ONE:

1609815794- Gerson, Benjamin
(all states except NY & CA)

1629057625- Walworth, Charles M
(CA ONLY)

1679500458- Cohen, Stephen H
(NY ONLY)

ITEM # 000000000000053683 FORM # 0702 (UNIVERSAL FREEFORM 07)

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 | UPIN | Physician's ID # | Patient's SS # | Patient's ID #

Physician's Name (Last, First) | Physician/Authorized Signature X

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

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service

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 hereon 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.

TRAVEL LOG ID

PST HR# | DATE | LOG#

PLEASE PRINT

PLEASE PRINT

[X] 262204- LP+Glu

Draw dates: 7/22/2017- 8/5/2017

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(REV:05JUN2015)

ORIGINAL-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.