



NEW ACCOUNT INFORMATION

FACILITY INFORMATION

Facility Name:		Registration Date:	
Street:	City:	State:	Zip:
Phone:	Phone 2:	Fax:	
Main Facility Contact:	Facility Type: <input type="checkbox"/> HHA <input type="checkbox"/> SNF <input type="checkbox"/> ALF <input type="checkbox"/> Clinic <input type="checkbox"/> MD Group		
Email:	Sample Type: <input type="checkbox"/> Wound <input type="checkbox"/> UTI <input type="checkbox"/> RPP <input type="checkbox"/> GI <input type="checkbox"/> STD		

PROVIDER INFORMATION

Provider Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> FNP	OTHER:	NPI #:
Medicare PTAN#:	Medicaid TIN#:		
Provider Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> FNP	OTHER:	NPI #:
Medicare PTAN#:	Medicaid TIN#:		

PAYOR SOURCE

Medicare: _____% Medicaid: _____% Tricare: _____% Work Comp: _____%

United: _____% Cigna: _____% BCBS: _____% Aetna: _____%

Humana: _____% WellCare: _____% Self Pay: _____% Other: _____%

BILLING/MISSING INFORMATION CONTACT

Billing Contact:		
Missing Information Contact:		
Billing Phone:	Billing Fax:	Billing Email:
Missing Information Phone:	Missing Information Fax:	Missing Information Email:

RESULT PREFERENCES & WEB PORTAL USERS *email for portal login details

Report Delivery Method:		
<input type="checkbox"/> Web Portal	<input type="checkbox"/> Fax	<input type="checkbox"/> EMR sync request
First Name:	Last Name:	Email
First Name:	Last Name:	Email

SUPPLIES TYPE & QUANTITY (estimated monthly volume)

Wound <input type="checkbox"/>	UTI <input type="checkbox"/>	RPP <input type="checkbox"/>	GI <input type="checkbox"/>	STD <input type="checkbox"/>
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Account Representative