NEW ACCOUNT FORM

Date: _____

Sales Group: _____ Sales Representative: _____ Rep Phone/Email: _____

Projected Start Date:

☐ Phlebotomist to be hired* ☐ Collector to be hired* *Please fill out the attached collector/phlebotomist request.

ACCOUNT INFORMATION				
Account Name	**Office Hours**	**Address**	**Phone**	**Fax**

PHYSICIAN INFORMATION		
Name (M.D, D.O, CRNP)	**NPI**	**Email**

OFFICE CONTACT		
Name	**Phone**	**Job Title**

ACCOUNT PREFERENCES

Pick-Up: ☐ Will Call ☐ Daily ☐ UPS ☐ Daily, Specific Day_____

Drop Box Location: _____

Pick-Up Special Instruction: _____

Report Delivery: ☐ Fax ☐ Web Portal ☐ Hard Copy ☐ EMR Integration

Interface Request: EMR Name: _____ EMR Contact / Phone _____

Critical/Malignancy Calls: ☐ Critical Clinical Results ☐ Malignancy After Hours Phone #: _____

BILLING INFORMATION

☐ Commercial (%) ☐ Client Bill ☐ Medicaid /Medicare

Estimated Volume_____

SUPPLY REQUEST

☐ Allergy ☐ Genetic Swabs ☐ GI ☐ Other ☐ Requisitions (Quantity / Type) _____

☐ Send Supplies To Account Representative ☐ Send to Account Attn

Physician Name (Printed)_____ **Physician Signature**_____

Date_____