



<b>Date Submitted:</b>	<b>Date Completed:</b>
<b>Client Start Date:</b>	<b>Salesperson:</b>
<b>Account #</b>	<b>By:</b>

## NEW ACCOUNT/ CHANGE FORM

<b>CLIENT/ CLINIC NAME:</b>	
<b>PHONE &amp; FAX</b>	<b>EMAIL:</b>
<b>ADDRESS:</b>	

Provider Name(s)	License #:	NPI #:
LIS Users	Email:	Phone #:

Physician's Signature: \_\_\_\_\_

Days of Operation:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From (Hours):							
To (Hours):							

Specimen Pickup Schedule		
Mon- Fri :	<input type="checkbox"/> Daily Before: _____ PM	<input type="checkbox"/> Call in (call for pick-up before 2 p.m.)
Saturday:	<input type="checkbox"/> Daily Before: _____ PM	<input type="checkbox"/> Call in (call for pick-up before <b>12</b> p.m.)
Sunday:	<input type="checkbox"/> Daily Before: _____ PM	<input type="checkbox"/> Call in (call for pick-up before 2 p.m.)
Do you require a lock box? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient Insurance Types	
Please circle ALL In-Network insurance companies	
Blue Cross    Anthem    Cigna    United    Healthnet    TriCare West    Aetna    Optima	
Current EMR/CRM system: _____	Do you need integration?   YES   NO