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NEW ACCOUNT SET-UP FORM

Today's Date: _____

Account Information			
Physician/Group Practice:			Office Manager Name/Number:
Address:			Lead MA Name/Number:
Address (Suite/Unit):			Billing Contact Name/Number:
City:	State:	Zip: 83201	Billing Type (check all that apply): ☐ Client ☐Patient/Insurance
Phone Number:	Fax Number:		Report Delivery Method(s): (check all that apply) ☐ Fax ☐ email ☐ Online Result Portal (LabNexus)
Email Address:			
After-Hours Contact (Critical Result Calls)**:**			

Courier Pickup Schedule					
Pickup Type (check one): ☐ Will-Call for Pickup ☐ Routine Route Pickup					
Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday

Physician Information			
Physician Name:	Specialty/Credentials:	NPI#	Online Result Portal Access: Y / N
1)			☐ Y ☐ N
2)			☐ Y ☐ N
3)			☐ Y ☐ N

EMR Interface Request (an Express Lab Rep will follow-up to discuss and approve)	
EMR Name:	Office Contact/IT Contact Name:
Account Rep Name:	Office Contact Phone:
Account Rep Phone:	Office Contact Email:
Account Rep Email:	Anticipated Start Date:

Return completed form to: marshall.holtom@idahomed.com