New Referring Provider Account Setup

Email form to: sbal@nath-mds.com OR vsharma@nath-mds.com

Fax to: 844-604-0145

Account Information

Clinic Name: _____

Address: _____

City : _____ State :_____ Zip:_____

Phone: _____ Fax:_____ Email Address:_____

Specialty: _____

Ordering Physician(s) Information

Provider name : _____ NPI_____PECOS regd? Y/N

Provider name : _____ NPI_____PECOS regd? Y/N

Provider name : _____ NPI_____PECOS regd? Y/N

Contact Information

Primary Contact Details

Name: _____ Title:_____

Phone: _____ Email Address: _____

Secondary Contact Details

Name: _____ Title:_____

Phone: _____ Email Address: _____

Clinic Information

Start Date: _____

Testing Type (Select One)

☐ **Traditional (Screening and Confirmation)** Billing Process: The physician's office **does not** bill for any testing.

☐ **Point of Care (CLIA waived Cup)** Billing Process: Principle HS bills for quantitative (LC/MS/MS) and physician's office bills for qualitative (screening).

☐ **Physician's Office Lab (Confirmation Only)** Billing Process: Principle HS bills for quantitative (LC/MS/MS) and physician's office bills for qualitative (screening).

Transition from Other Service: ☐ Yes ☐ No

Current Lab : _____

Reporting

Fax : ☐ Yes ☐ No Fax Number: _____

APC HEALTH LLC, 2817 MILLER RANCH RD, SUITE 317, PEARLAND TX 775841
TELEPHONE: (281) 240-0974, FAX: (844) 604-0145

E-mail: ☐ Yes ☐ No Email Address: _____

Pickup Service

Pickup needed ☐ Yes ☐ No

If Yes Indicate ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri Time: _____

☐ Will call when needed

Supplies Requested

90 ml Cups : ☐ Other Supplies : _____

Sales Rep Information

Agency: _____ Name: _____

Phone: _____ Email Address:_____

Internal Use Only

Approved by: _____ Account Number:_____

Supplies Provided:_____

Date Shipped:_____ Profiles:_____

Service Date:_____

_____ _____ _____

Provider Name (Please Print) Provider Signatures Date

APC HEALTH LLC, 2817 MILLER RANCH RD, SUITE 317, PEARLAND TX 775842
TELEPHONE: (281) 240-0974, FAX: (844) 604-0145