



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: _____

E-mail: Yes No Email Address: _____

APC HEALTH LLC, 2817 MILLER RANCH RD, SUITE 317, PEARLAND TX 77584
TELEPHONE: (281) 240-0974, FAX: (844) 604-0145

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