EQUILIBRIUM DIAGNOSTICS

Account Registration - New

Projected Start Date:_____

A PRACTICE INFORMATION

Practice Name: _____ Contact Name: _____

Street Address: _____ Contact Phone: _____

_____ Contact Email: _____

City, State Zip: _____ Provider Type: _____

Phone: _____ Patients Per Day: _____

Fax: _____ Send Results via: ☐ *Fax* ☐ *Web-Portal* ☐ *Email*

Clinic Tax ID#: _____

Practice NPI#: _____

Lab Service Requested	EST. Vol		EST. Vol
Toxicology Urine		Molecular (RPP/Covid, UTI/STI, GI, Wound, Toenail	
Toxicology Oral		PGX	
Blood		CGX	

Hours of Operation		Time Zone	X
Monday		EST	
Tuesday		CST	
Wednesday		MST	
Thursday		PST	
Friday			

(Please note, the Contact Person will receive all clinic correspondence and portal access. If no contact name and email is provided, the account cannot be registered.

B PROVIDER INFORMATION – Required Information to Process Registration

NPI NUMBER	PROVIDER NAME (M.D., D.O., CRPN,	PROVIDER

FOR ALL NEW ACCOUNTS, WE MUST RECEIVE CONFIRMATION OF THE ORDERING PROVIDER'S SIGNATURE. PLEASE HAVE THE ORDERING PROVIDER SIGN OFF AND ACKNOWLEDGE THEIR SIGNATURE ON A VOIDED PRESCRIPTION ORDER FORM OR THE EQUDX SIGNATURE VERIFICATION FORM

Main Contact for Specimen Handling _____

Need Specimen Pickup: Yes ___ No ___ Days needed:(Circle) M T W Th F

TOX: Does the clinic intend to bill for presumptive screening? Yes ☐ No ☐

Account Representative

Name: _____

Phone #: _____ Email: _____

EQUILIBRIUM DIAGNOSTICS

Please email Account Registration Form to:cservice@equdx.com
or Fax to 210-474-0011 Phone: 210.903.0551

08.15.23

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CRITICAL RESULTS AND AFTER HOUR CONTACT (If different than Contact Name listed on front page)

Contact:	
Phone:	Fax:
Email:	

BILLING/MISSING INFORMATION CONTACT (If different than Contact Name listed on front page)

Contact:	
Phone:	Fax:
Email:	

Do you grant EDX permission to provide diagnostic management services and reference these specimens to an approved CLIA/COLA certified laboratory of our designation to run and result these specimens? Yes or No (Please circle)

Do you authorize EDX Lab to obtain Prior Authorization on behalf of your patients, should the patient plan require a Prior Authorization prior to testing?
Yes or No (Please circle)

BY:_____ Date:_____

_____
(Print Name)

Internal Use Only:

Account Manager Review: _____ Date:_____
Signature

Account #: _____

Pick-Up: [ ] UPS [ ] Local Courier [ ] Fed X

Pick-Up Time:_____ M T W Th F

Webportal Setup:

Username:_____

Password:_____

Name:_____ Email:_____

Name:_____ Email:_____

Name:_____ Email:_____

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Signature/Name Verification

This is to certify that my legal signature is as written and typed/printed below. This signature must exactly match signatures on all Provider Documents. It must also be signed in the presence of a witness as a secondary verification that the signature belongs to the provider indicated.

_____ _____

(Print or Type Provider Name) Provider Signature

NPI No: _____ Date: _____

_____ _____

(Print or Type Witness Name) Witness Signature

Date: _____

Authorization For Electronic Signature

This request is to have your signature on file, to ensure that your electronic orders are verified with your full intent and knowledge; by having your signature on file, you will be able to maintain your patient's records and electronically sign your clinical orders.

This is to confirm your signature will be encrypted and will only be used for the sole purpose of ordering diagnostic tests for your patients, in compliance with HIPPA standards. Should you choose to remove your signature at any time, please notify us, and it will be removed.

Please ensure signature fits inside box.