BioClinical LABS

ACCOUNT SETUP FORM

CHECK ALL THAT APPLY

☐ COVID-19 ☐ CLINICAL

PRIMARY FACILITY - ACCOUNT INFORMATION

FACILITY/PRACTICE NAME | START DATE | HOURS OF OPERATION

FACILITY/PRACTICE ADDRESS

CITY | STATE | ZIP CODE

DIRECTOR OF NURSING NAME | PHONE NO. | FAX NO. | EMAIL ADDRESS

OFFICE MANAGER NAME | PHONE NO. | FAX NO. | EMAIL ADDRESS

BILLING MANAGER NAME | PHONE NO. | FAX NO. | EMAIL ADDRESS

PRIMARY FACILITY PHYSICIAN INFORMATION

PHYSICIAN NAME (LAST, FIRST)	SPECIALITY	NPI	PHONE	EMAIL ADDRESS
1				
2				
3				
4				

COLLECTOR INFORMATION

COLLECTOR LAST NAME | COLLECTOR FIRST NAME | PHONE NO. | EMAIL ADDRESS

TEST RESULTS

ACKNOWLEDGEMENT FORM COMPLETED ☐ FAX RESULTS ☐ WEB PORTAL ACCESS ☐

TEST RESULTS FAX NUMBER | WEB PORTAL EMAIL

OPTIONAL AUTOMATIC PICKUP: Indicate requested days. Pickups will be scheduled for the end of the day unless otherwise specified.

UPS ☐ COURIER ☐

OTHER:

Return to: mailto:dcorona.bioclinicallabs@gmail.com