



NEW ACCOUNT/ ACCOUNT CHANGE FORM

Date Submitted:	Date Completed:	By:	
Client Start Date:			
Account Number:	Salesperson:		
Account Information			
Client (Clinic) Name:			
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Provider Name(s):	<u>License #</u>	<u>NPI #</u>	
Email:	Phone #:		
Contact Information			
Office Contact(s)	Title	Phone Number	

Days of Operation Monday Tuesday Wednesday Thursday Friday Saturday Sunday

From (Hours) _____ _____ _____ _____ _____ _____ _____

To (Hours) _____ _____ _____ _____ _____ _____ _____

Do you require a lock box? Yes No

Reporting preference (please check): Fax Email Portal

Specimen Pick-up Schedule

Monday – Friday: Daily Before: _____ PM or Call in (please call for pickup before 2 PM).

Critical value reporting

Call all criticals Fax all critical

Special Instructions:

AUTHORIZATION

I authorize Biogene Diagnostics to perform testing on patients from my practice as directed by the individual patient test requisition form as well as the provided Custom Profile on file. I understand that it is the facility's practitioner's responsibility to determine the medical necessity of each test requested through the individual patient test requisition form and Custom Profile.

Authorized Person Name and Signature: _____