QUALITY LABORATORY SERVICES

ACCOUNT SETUP FORM

PLEASE NOTE: THIS FORM MUST BE COMPLETED PROPERLY TO PROMPTLY PROCESS YOUR REQUEST.

DATE: _____ SALES GROUP #_____

NOTE: PLEASE MAKE SURE TO INCLUDE PRACTICE NAME IF APPLICABLE.

PRACTICE NAME (IF APPLICABLE): _____

ADDRESS: _____

CITY_____STATE:_____ZIP:_____

TELEPHONE #_____ FAX #_____

LIST ALL THE DOCTORS WHO ARE BEING SETUP FOR THIS PRACTICE AND LOCATION.

DOCTOR # 1

LAST NAME: _____

FIRST NAME: _____

LICENSE # _____

UPIN #_____

NPI # _____

DOCTOR # 2

LAST NAME: _____

FIRST NAME: _____

LICENSE # _____

UPIN #_____

NPI # _____

OFFICE CONTACT PERSON: _____

EMERGENCY CONTACT NAME AND NUMBER: _____

OFFICE HOURS:

MON _____
TUE _____
WED _____
THU _____
FRI _____
SAT _____
SUN _____

LABGEN PORTAL:

USERNAME: _____

PASSWORD: _____

NOTE: Please attach another "ACCOUNT SETUP FORM" for additional doctors.