ADVANTA ANALYTICAL LABORATORIES

NEW PHYSICIAN REGISTRATION FORM

Please complete registration form and fax to 903.839.2494. You may also email the form to registration@aalabs.com.

☐ INFECTIOUS DISEASE ☐ MOLECULAR ☐ WOMEN'S HEALTH ☐ PHARMACOGENETICS ☐ TOXICOLOGY

PROVIDER INFORMATION

Ordering Physician's Full Name: _____ Credentials: _____
Last Name, First Name — MD/DO/FNP/PA

Ordering Physician's NPI #: _____

Name of Medical Practice: _____

Name of additional Provider(s) and/or Mid-Level(s):

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

CLINIC LOCATION ADDRESS – *Additional providers and locations on page 2*

Address for clinic location(s) where orders will be placed and samples will be collected:

Primary Location: _____ City: _____ State: _____ Zip: _____
Street Number & Name — Suite

Phone: _____ Fax: _____

Specimen Cup: Clear Specimen Collection Cups ☐ Point of Care Collection Cups ☐

Anticipated Monthly Volume: _____

Point of Contact Name: _____ Phone: _____

Email: _____ Implementation Date: _____

HOURS OF OPERATION (MON–WED)				HOURS OF OPERATIONS (THURS–SAT)			
Primary Location	Open Time	Close Time	Shipping Pick-Up Time	Primary Location	Open Time	Close Time	Shipping Pick-Up Time
Monday				Thursday			
Tuesday				Friday			
Wednesday				Saturday			
				Will shipping pick-up need to be coordinated?			YES NO
							FedEx or UPS

Please mark "NA" for days UPS/FedEx does not need to pick-up.

SUPPLY REQUEST(S) OR SPECIAL REQUEST(S):

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ADDITIONAL PROVIDER(S) AND/OR MID-LEVEL(S)

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

_____ Credentials: _____ NPI #: _____
Last Name, First Name

ADDITIONAL LOCATIONS

Additional Location: _____ City: _____ State: _____ Zip: _____
Street Number & Name Suite

Phone: _____ Fax: _____

Practice Name (If different from Primary): _____

HOURS OF OPERATION (MON–WED)				HOURS OF OPERATIONS (THURS–SAT)			
Primary Location	Open Time	Close Time	Shipping Pick-Up Time	Primary Location	Open Time	Close Time	Shipping Pick-Up Time
Monday				Thursday			
Tuesday				Friday			
Wednesday				Saturday			
				Will shipping pick-up need to be coordinated?			YES NO
Please mark "NA" for days UPS/FedEx does not need to pick-up.							FedEx or UPS

Additional Location: _____ City: _____ State: _____ Zip: _____
Street Number & Name Suite

Phone: _____ Fax: _____

Practice Name (If different from Primary): _____

HOURS OF OPERATION (MON–WED)				HOURS OF OPERATIONS (THURS–SAT)			
Primary Location	Open Time	Close Time	Shipping Pick-Up Time	Primary Location	Open Time	Close Time	Shipping Pick-Up Time
Monday				Thursday			
Tuesday				Friday			
Wednesday				Saturday			
				Will shipping pick-up need to be coordinated?			YES NO
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Acknowledgment of Ordering Practitioner | Predefined Customer Profile Attestation

1. Decisions on ordering laboratory testing are based solely on the medical necessity for a specific medical condition and the results used in the management of a specific medical condition. The provider understands that when ordering tests for which Medicare reimbursement will be sought, the treating provider should only order those tests which the physician believes are medically necessary for each patient. The undersigned providers have been informed that the Office of Inspector General (OIG) takes the position that a provider who orders medically unnecessary tests may be subject to civil penalties.
2. By singing this form, it is hereby certified that the treating physician shall review the volume, frequency, and duration of testing and order laboratory testing accordingly and in accordance with clinical indication and medical necessity.
3. By signing this form, I acknowledge if any Point of Care (POC) device is provided by the lab I will not directly or indirectly bill or collect a fee for POC testing without submitting payment to the lab for the device at a fair market value rate. I agree and understand the device will be used solely to collect, transport, process, or store specimens referred to the lab for testing. I acknowledge and understand that use of the POC device for any other purpose or billing for POC testing with laboratory-provided POC devices without remitting payment for same to the lab could be interpreted as a violation of Anti-Kickback Statue 42 U.S.C. § 1320a-7b.
4. I acknowledge if any POC device is provided by the lab and I remunerate off any service in which the device is used, I will receive an invoice and remit payment for the device at fair market value.
5. It is agreed that all supporting medical necessity documentation should be available, legible, and maintained in the patient's medical record.
6. I verify that I am ordering samples for testing to be performed at Advanta Analytical Laboratories and its affiliated contracted laboratories.
7. The signatories hereto understand there may be applicable National Coverage Determinations and Local Coverage Determinations for clinical laboratory testing.

I acknowledge Advanta Analytical Laboratories has provided me with information regarding its policies and guidelines for laboratory testing to my satisfaction.

Practice Name: _____

Physician's Printed Name: _____

Physician's NPI: _____

Physician's Signature: _____