CORE BIO LABS

A DIVISION OF CMCD

Account Registration

REPRESENTATIVE INFORMATION

Account Rep Name:	**Account Rep Phone:**
Distribution Group:	**Distribution Group Phone:**

ACCOUNT & FACILITY INFORMATION

Facility Name:	**Phone:**	**Fax:**	
Contact Name:	**Contact Email:**		
# of Patients/Mo:	**# of New Patients/Mo:**		
Address:	**City:**	**State:**	**Zip:**

How would you like to receive reports? ☐ Web Portal ☐ Fax ☐ Email

Email for Portal Access:

PHYSICIAN INFORMATION

Provider 1 Name:	**Provider 1 Designation:** ◯ MD ◯ DO ◯ NP ◯ PA ◯ DPM	
Provider 1 NPI#:	**Provider 1 PTAN#:**	**Provider 1 TIN#:**
Provider 2 Name:	**Provider 2 Designation:** ◯ MD ◯ DO ◯ NP ◯ PA ◯ DPM	
Provider 2 NPI#:	**Provider 2 PTAN#:**	**Provider 2 TIN#:**
Provider 3 Name:	**Provider 3 Designation:** ◯ MD ◯ DO ◯ NP ◯ PA ◯ DPM	
Provider 3 NPI#:	**Provider 3 PTAN#:**	**Provider 3 TIN#:**

LAB STUDIES

CATEGORY		VOLUME	CATEGORY		VOLUME
Pharmacogenetics (PGx):	◯ Yes ◯ No		**Molecular (GPP):**	◯ Yes ◯ No	
Urine Cytology/FISH:	◯ Yes ◯ No		**Molecular (RPP):**	◯ Yes ◯ No	
Molecular (Wounds):	◯ Yes ◯ No		**Women's Health:**	◯ Yes ◯ No	
Molecular (Nails):	◯ Yes ◯ No		**Addiction Medicine:**	◯ Yes ◯ No	
Molecular (UTI):	◯ Yes ◯ No		**Toxicology:**	◯ Yes ◯ No	

PAYOR MIX

	% of Business		% of Business	Medicaid Payors	% of Medicaid
Medicare		**Humana**			
Medicaid		**Aetna**			
BCBS		**Private Pay**			
UHC		**Legal**			
Cigna		**VA**			

Supplemental Insurers:

Volume of No-Charge Patients/Month:

SHIPPING INFORMATION

* **Do you have a regular UPS pickup or drop box?** ◯ Yes ◯ No	* **Do you have a regular FedEx pickup or drop box?** ◯ Yes ◯ No

Please send the completed form via Email: info@corebiolabs.com

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Acknowledgement and Signature Form

I understand that I can contact the Lab's lab directors should I have questions regarding the appropriateness of any test order.

I hereby acknowledge that the Labs will perform the testing indicated above for patients from my practice as directed by my Test Requisition Form.

I understand that it is my responsibility to determine the medical necessity of tests I have requested for the treatment and/ or diagnosis of my patients.

I agree to provide diagnosis codes, defined to the highest level of specificity, for each test that I order in order to confirm medical necessity and to enable the Labs to bill effectively on my patient's behalf. Tests that are deemed medically unnecessary may result in a denial of payment and/or penalties.

I understand that the Office of Inspector General (OIG) has cautioned: "Using a customized profile may result in the ordering of tests which are not covered, reasonable, or necessary" and "OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law."

I understand that the Labs will be billing third parties for the tests I ordered using the CPT codes noted in the Annual Notice to Physicians.

In the event that Medicare, Medicaid, or other insurance providers request documentation, I will provide signed patient's medical records to the requesting party within 72 hours.

In cases of multiple physicians within a group practice, each practitioner must indicate their acknowledgment by signing below:

Provider Name:	**Provider Email:**
Provider Signature:	**Date:**
Provider Name:	**Provider Email:**
Provider Signature:	**Date:**
Provider Name:	**Provider Email:**
Provider Signature:	**Date:**
Provider Name:	**Provider Email:**
Provider Signature:	**Date:**
Provider Name:	**Provider Email:**
Provider Signature:	**Date:**