NEW ACCOUNT REGISTRATION FORM

CORE B🧬O LABS
Precise • Comprehensive • Reliable

REPRESENTATIVE

Account Rep Name: _____   Account Rep Phone: _____

ACCOUNT & FACILITY

Account Type: Physician office   Home Health Care Services   ALF/SNF   Other: _____

Facility/Practice Name: _____   Phone: _____   Fax: _____

Address: _____   City: _____   State: _____   Zip: _____

Contact Name: _____   Contact Email: _____

REPORTS & LOGISTICS

Reporting Type: Web Portal   Fax   Account Start Date: _____

Name for Portal Access: _____   Email for Portal Access: _____

Shipping Preference: FedEx   UPS   Pickup Schedule requested: Yes   No   Enroll in UPS Complete View Returns   Yes   No

Days per Week: Mon   Tue   Wed   Thu   Fri   Preferred 2 Hour Block: 2-4PM   3-5PM   Other _____

TESTING VOLUME

Category	Monthly Volume	Category	Monthly Volume	Category	Monthly Volume
UTI PCR		Wound PCR		PGX	
RPP PCR		Nail PCR		Urine Cytology/FISH	
COVID-19 PCR		Toxicology		Other	

PAYOR MIX

Insurance	% of Patients	Insurance	% of Patients	Insurance	% of Patients
Medicare		United HC		VA	
Medicaid		Aetna		Humana	
BCBS		Cigna		Legal	
Self-Pay		Worker's Comp		Other	

ACKNOWLEDGEMENT & SIGNATURE

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:		NPI Number:		Provider Name:		NPI Number:	
Provider Signature:		Date:		Provider Signature:		Date:	
Provider Name:		NPI Number:		Provider Name:		NPI Number:	
Provider Signature:		Date:		Provider Signature:		Date:	
Provider Name:		NPI Number:		Provider Name:		NPI Number:	
Provider Signature:		Date:		Provider Signature:		Date:	
Provider Name:		NPI Number:		Provider Name:		NPI Number:	
Provider Signature:		Date:		Provider Signature:		Date:	

CoreBioLabs • 7956 Tyler Boulevard Mentor, Ohio 44060 • Phone: (330) 405-2623 • Fax: (330) 405-0859
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Revision 5.0 05/16/2022

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Client Name: _____   Phone: _____   Fax: _____

Client Address: _____   City: _____   State: _____   Zip: _____

TOXICOLOGY URINE & ORAL FLUID TESTING

I want to create a custom panel consisting of the tests indicated below.   Yes   No

Screen Test (**SCR**) Confirmation Test (**CFT**)
Reflex Test (**RFX**) Oral Fluid Test (**ORF**)
*Select one box for each test.

Column 1

	SCR	CFT	RFX	ORF
Alcohol	☐	☐	☐	
Ethyl glucuronide		☐	-	
Ethyl sulfate		☐	-	
Amphetamines	☐	☐	-	☐
Amphetamine		☐	☐	☐
Methamphetamine		☐	-	☐
Anticonvulsants	☐	☐	☐	
Carbamazepine		☐	-	
Gabapentin		☐	-	
Lamotrigine		☐	-	
Pregabalin		☐	-	
Barbiturates	☐	☐	☐	
Butalbital		☐	-	
Phenobarbital		☐	-	
Benzodiazepines	☐	☐	-	
Alprazolam		☐		☐
a-Hydroxyalprazolam		☐		
Diazepam		☐	☐	☐
Nordiazepam		☐		☐
Oxazepam		☐		☐
Temazepam		☐		☐
a-Hydroxytriazolam		☐	-	
Chlordiazepoxide		☐	-	
Clonazepam		☐	-	☐
7-aminoclonazepam		☐	-	
Flunitrazepam		☐	-	
Flurazepam		☐	-	
Desalkylflurazepam		☐	-	
Lorazepam		☐	-	☐
Midazolam		☐	-	☐
Buprenorphine	☐	☐	☐	☐
Buprenorphine		☐	-	☐
Norbuprenorphine		☐	-	☐
Naloxone		☐	-	☐
Cocaine	☐	☐	☐	☐
Benzoylecgonine		☐	-	
Heroin	☐	☐	☐	
6-AM		☐	☐	☐

Column 2

	SCR	CFT	RFX	ORF
Illicit Drugs	☐	☐	-	
Acetyl fentanyl		☐	☐	
Carfentanil		☐	☐	
Ketamine		☐	☐	
Norketamine		☐	☐	
MDA,MDEA,MDMA (Ecstasy)		☐	☐	☐
Mitragynine		☐	☐	
Phencyclidine (PCP)		☐	☐	☐
Muscle Relaxants		☐	-	
Carisoprodol		☐		☐
Meprobamate		☐	☐	☐
Cyclobenzaprine		☐		
Norcyclobenzaprine		☐	-	
OTC		☐	☐	
Dextromethorphan		☐	-	
Diphenhydramine		☐	-	
Pseudoephedrine		☐	-	
Methadone	☐	☐	☐	
Methadone		☐	-	☐
EDDP		☐	-	
Opiates	☐	☐	-	
Codeine		☐		
Morphine		☐	☐	☐
Hydrocodone		☐	-	
Norhydocodone		☐	-	
Hydromorphone		☐	-	☐
Fentanyl analogues		☐	☐	☐
Norfentanyl		☐	☐	
Opioids	☐	☐	-	
Meperidine		☐	☐	
Normeperidine		☐	☐	
Propoxyphene		☐	☐	
Norpropoxyphene		☐	☐	
Sufentanil		☐	☐	
Tapentadol		☐	☐	
Tramadol		☐	☐	☐
O-Desmethyltramadol		☐	☐	

Column 3

	SCR	CFT	RFX	ORF
Oxycodone	☐	☐	☐	
Oxycodone		☐	-	☐
Oxymorphone		☐	-	☐
Noroxycodone		☐	-	
Sedatives/Hypnotics		☐	☐	
Zolpidem		☐	-	
Carboxy-zolpidem		☐	-	
Synthetic Cannabinoids	☐	☐	☐	
AM2201 Hydroxypentyl		☐	-	
JWH-073 4-Butanoic Acid		☐	-	
JWH-250 Hydroxypentyl		☐	-	
UR-144 Hydroxypentyl		☐	-	
XLR-11 Hydroxypentyl		☐	-	
Synthetic Stimulants		☐	☐	
MDPV		☐	-	
Mephedrone		☐	-	
Methedrone		☐	-	
Methylone		☐	-	
THC	☐	☐	☐	☐
THC-COOH		☐	-	
Miscellaneous		-	-	
Clonidine		-	☐	
Cotinine		-	☐	
Naltrexone		-	☐	
Promethazine		-	☐	
Ritalinic Acid		-	☐	
Anti-psychotics		-	-	☐
Quetiapine				☐

CUSTOM PANEL ACKNOWLEDGEMENT & SIGNATURE

As part of my medical practice's prescription medication management and compliance protocols, I authorize CoreBioLabs to create on my behalf, a custom panel for the testing of analytes/metabolites of my choosing that I have selected by checking the applicable boxes above and that will be used to test patients from my practice. I understand and acknowledge that I must only order tests for patients that are required medically for the purpose of monitoring their individual drug compliance protocol and do confirm that this is the purpose of this custom panel request. I also understand and acknowledge that each of the selected tests in the custom panel will be billed separately using the CPT codes available with this form unless otherwise indicated.

Ordering Provider Name: (required) _____   Provider NPI Number: (required) _____

Ordering Provider Signature: (required) _____   Date: (required) _____

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