PHI LIFE SCIENCES - FACILITY ENROLLMENT FORM

To create access to the Phi Life Sciences Portal we will need you to fill out the onboarding form below. Please note: the fields noted with a * are mandatory. Your application will be returned if we are missing any mandatory information. Please contact us if you have any questions regarding this form: **888.576.5445 ext. 1**. or email **cmcollins@philifesciences.com.**

EMAIL THIS COMPLETED FORM TO: dorothy@philifesciences, kerry@philifesciences, anna@philifesciences and cmcollins@philifesciences.com.

Distributor / Marketing Rep Name:*			
Facility Name:*			
Facility Phone:*			
HIPAA Fax:*			
Facility Street Address:*			
Facility City:*	**Facility State:***	**Facility Zip:***	
Facility Billing Options* (select all that apply) **❑ Invoice ❑ Self-Pay ❑ Insurance ❑ No Insurance**	**Hospice Patients** ❑ Yes ❑ No	**Insurance % Private**	**Insurance % Medicare**
Physician Name:*		**NPI#:***	
Physician Email:*			
Office Manager Name:*			
Office Manger Phone:*			
Office Manager Email:*			
Office Hours of Operation:			

Practice Products:* (select all that apply) Infectious Diseases: ❑ COVID-19 ❑ COVID-19+RSV 1&2+FLU A-B
❑ COVID-19 IMMUNITY ADITXTSCORE™ ❑ UTI ❑ Fungal ❑ RPP ❑ Wound Genetic Testing: ❑ PGx ❑ CGx
Other: ❑ Toxicology ❑ Hematology/Gen Chemistry ❑ Immunodeficiency

Test Delivery Options*
❑ HIPAA Fax ❑ US Mail ❑ Electronic Lab Records Interface ❑ Patient Email

Invite to Web Portal:* (at least one person per facility must have access to their box account)
Name: _____ **Email:** _____
Name: _____ **Email:** _____
Name: _____ **Email:** _____
Name: _____ **Email:** _____

SUPPLIES NEEDED TO GET STARTED:

SUPPLY ORDERS SHIP WITHIN 48 HOURS OF RECEIPT OF THE ORDER - ALL EXPRESS SHIPPING REQUESTS REQUIRE PLS AUTHORIZATION
IF SHIPPING IS OTHER THAN THE ADDRESS OF THE FACILITY, PLEASE SUPPLY THE SHIPPING ADDRESS, CONTACT NAME AND PHONE NUMBER NOTES BLEOW:

❑ Ship to Facility ❑ Ship to Marketing Rep
❑ Ground ❑ 2 Day ❑ Standard Overnight ❑ Priority Overnight ❑ Saturday Delivery

Count	Bulk	Kit	Product Description

Notes:

PHI LIFE SCIENCES - SIGNATURE ATTESTATION STATEMENT

Facility Name: _____

Phi Life Sciences requires that we maintain a registry of provider signatures for verification when signature stamps and/or electronic signatures will be used in place of actual signatures or when the clinician would like to have his/her signature on file rather than signing each test requisition.

I, _____hereby attest that all patient samples, lab requisitions, medical necessity forms, notations and medical records sent to Phi Life Sciences with my signature stamp and/or electronic signature or signature on file from this point forward are by my request. I also attest that this stamp is NOT to be used for the purpose of ordering or prescribing patient medication(s).

Signature: _____ Initials: _____

Name: _____ NPI#: _____

Signature Stamp(s): _____

Date: _____