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 1-833-FOOD ALLERGY

# New Account

## Account Information

CLINIC NAME:		
ADDRESS 1:		
CITY:	STATE:	ZIPCODE:
PHONE:	FAX:	EMAIL:

## Office Contact Information

CONTACT NAME:		CONTACT TITLE:
PHONE:	FAX:	EMAIL:
ESTIMATED MONTHLY KIT VOLUME:		

## Physician Signature Record

**PLEASE INCLUDE ALL PROVIDERS WHO ARE AUTHORIZED TO ORDER LAB TESTING.**

LAST NAME, FIRST NAME	NPI#	TITLE	SIGNATURE	DATE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are any practitioners in your office PECOS registered? \_\_\_\_\_ **In order for Infinite Allergy Labs to bill Medicare on the patient's behalf, the prescribing doctor MUST be PECOS registered.**

## Billing Information

**BILLING TYPE:**  INSURANCE  CLINIC  PATIENT

## CREDIT CARD INFORMATION

NAME ON CREDIT CARD:	
CARD TYPE:	
CARD NUMBER:	
EXPIRATION DATE:	SECURITY CODE:

## Reporting Preferences

**REPORTING METHOD** WEB PORTAL (PORTAL SITE: [HTTPS://INFINITELABSPORTAL.WAVEFRONTSOFTWARE.COM](https://infinitelabportal.wavefrontsoftware.com))

DESIRED USERNAME: \_\_\_\_\_ DESIRED PASSWORD: \_\_\_\_\_

**CHOOSE 6 LETTER/NUMBER COMBINATION (NOT CASE SENSITIVE)**

## Shipping Information

**DAILY PICKUP NEEDED:**  YES  NO

PICKUP TIME NEEDED: \_\_\_\_\_ LOCATION OF PICKUP: \_\_\_\_\_

SALES REP: \_\_\_\_\_ SALES REP EMAIL: \_\_\_\_\_ DATE: \_\_\_\_\_

Infinite Allergy Labs accepts commercial insurances with OON (Out Of Network benefits), provided the remaining out of network deductible is \$3000 or less. We also accept Medicare Part A & B provided the test is prescribed by a PECOS enrolled practitioner. We do not accept Medicaid, HMOs or insurance with no available OON benefits.  
 Please contact us to verify patient eligibility at 678-971-5256