P: 913-522-6352
F: 913-261-9117
www.mokanlabs.com
CLIA ID: 17D2273601

NEW ACCOUNT INFORMATION

Facility Information

Facility Name: _____ Date: _____

Facility Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Phone (2): _____ Fax: _____

Hours of Operation: _____

Facility Specialty: _____ EMR Vendor: _____

Account Preferences

Laboratory Report Delivery Method: (must choose one) *additional paperwork required

☐ Ovation (Online Portal) ☐ Fax ☐ EMR Interface*

If selecting online portal, designate your Primary User(s)

First Name: _____ Last Name: _____ Email: _____

First Name: _____ Last Name: _____ Email: _____

First Name: _____ Last Name: _____ Email: _____

Specimen Pickup Schedule: Email clientservices@mokanlabs.com for as needed or Recurring

(select days/times below)

M	T	W	Th	F	Sat	Sample Pick Up Area:
1 Hour Window: _____	1 Hour Window: _____	1 Hour Window: _____	1 Hour Window: _____	1 Hour Window: _____	1 Hour Window: _____	☐ Front Desk ☐ Other: ☐ Back Door **UPS Placard Pick-up Request:** ☐ Daily ☐ On-Demand

Additional Account Information

Estimated Payor Mix:

Medicare: _____%

Medicaid: _____%

Private Ins: _____%

Client Bill: _____%

Self-Pay: _____%

Estimated Monthly Sample Volume:

UTI: _____

STI: _____

Kidney Stone: _____

LVRP: _____

Ovation (Provider Portal) Notification Preference:

☐ Fax Reports

☐ Email Report Notifications

☐ Both

**Preferences may be changed in Provider Portal at any time*

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Provider Authorization(s)

Test Orders: Provider Signature Log, E-Signatures, Medical Necessity

As a provider, I acknowledge that I am authorized to order laboratory tests. I understand that Mokan Labs, LLC requires each lab requisition or order submitted to be signed by a provider and that each signature must be a legible, handwritten, full signature with credentials, handwritten initials, or electronic signature. Stamped signatures are not acceptable. Documentation with initials or illegible signatures must include a signature log with a typed or printed name, credentials and a sample of the signature and initials.

Additionally, I acknowledge and authorize that my signature below may be used by Mokan Labs, LLC as my electronic signature for electronic test orders through the Ovation Web Portal or other electronic ordering platforms such as electronic medical records (EMR), as necessary, for all future orders and any previous orders. Further, to the extent that any paper requisition/test orders are or were submitted without the required legible, handwritten, full signature with credentials, I authorize the past, present, and future reliance on and use of my signature below to support Mokan Labs, LLC performing the tests listed on these requisitions/orders.

I acknowledge that I may order tests from Mokan Labs, LLC within my EMR. I confirm that my EMR order(s) correspond to the entire respective Mokan test panel. All targets within any of the panels offered by Mokan Labs are individually orderable though a paper requisition form or Mokan's online portal (ex: any combination of individual organisms, antibiotic resistance genes, ect). Mokan Labs may update each test panel from time to time. Panel updates will be communicated to all clinics by Mokan Labs.

Medical necessity for all testing is of the utmost importance for patients, providers, and laboratories alike. I acknowledge that only tests deemed medically necessary will be ordered. I attest that each test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. Additionally, all healthcare provider clinical notes will specifically document the Mokan test ordered.

ACCOUNT NAME: _____

Provider Signature: _____

Provider Initials (if used for signature): _____

Provider Name (print or type): _____ Date: _____

Credentials: _____ Provider Email: _____

NPI: _____ Facility/Account: _____

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Provider Signature: ____

Provider Initials (if used for signature): ____________________

Provider Name (print or type): ______________________________Date: ____________________

Credentials: ________________Provider Email: ______________________________

NPI: ______________________Facility/Account:______________________________

Provider Signature: ____

Provider Initials (if used for signature): ____________________

Provider Name (print or type): ______________________________Date: ____________________

Credentials: ________________Provider Email: ______________________________

NPI: ______________________Facility/Account:______________________________

Provider Signature: ____

Provider Initials (if used for signature): ____________________

Provider Name (print or type): ______________________________Date: ____________________

Credentials: ________________Provider Email: ______________________________

NPI: ______________________Facility/Account:______________________________

Provider Signature: ____

Provider Initials (if used for signature): ____________________

Provider Name (print or type): ______________________________Date: ____________________

Credentials: ________________Provider Email: ______________________________

NPI: ______________________Facility/Account:______________________________