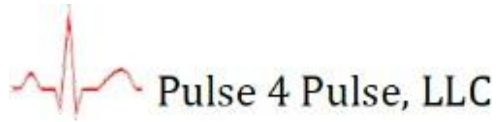

New Practice Submission Form

Representative:____DATE: ______________________

PRACTICE INFORMATION

Legal Name of Practice: ____

Practice Type: ____

Practice Primary Address: ____

Additional Locations: ____

Main Phone:____________________________________FAX: ____________________________________

Number of Locations:__________________________Number of Doctors: __________________________

Patient Volume per Month:_______________ Expected number of tests per month: _____________

Practice Days / Hours: ____

Payer Mix and %:

1. Name____________________________%_____ 2. Name_______________________________%_____
3. Name____________________________%_____ 4. Name_______________________________%_____
5. Name____________________________%_____ 6. Name_______________________________%_____
7. Name____________________________%_____ 8. Name_______________________________%_____

All Practicing Doctors Name and Specialties: ____

____

PRIMARY CONTACT (Physician/Owner):

PRIMARY NAME____TITLE ___________________

PHONE_________________________________EMAIL ____

OFFICE MANAGER CONTACT INFORMATION:

PRIMARY NAME____TITLE ___________________

PHONE_________________________________EMAIL ____

BILLING MANAGER CONTACT INFORMATION:

PRIMARY NAME____TITLE _________________

PHONE_________________________________EMAIL ____

DOES PRACTICE USE 3rd PARTY BILLING PARTY? Y / N name: ____________________________________

Pulse4Pulse Service: Will PRACTICE USE P4P BILLING or SELF-BILL _________________________________