# ACCOUNT AUTHORIZATION FORM

## INSTRUCTIONS

1. PRINT CLEARLY when providing required information to ensure timely processing; attach additional pages as needed.
2. Upon completion, FAX this form to: 808-451-3424; OR EMAIL this form to: cs@ohanalab.com

## SALES REP INFORMATION *(required)*

Last Name: First Name: Phone No. Email Address: Date:

## PRIMARY ACCOUNT LOCATION INFORMATION *(required)*

Practice/Facility/Clinic Name: Facility ID: Office Contact Name: Email Address:

Practice/Facility/Clinic Address: City: State: Zip Code:

Phone No. Afterhours Phone No. (for critical results): Fax No.

Average Census (for Facilities/Nursing Homes): Projected Start Date:

Type of Facility

□ Detox/Rehab □ Hospital/ Clinic □ Sober Living Home □ Other: _____ *(specify)* Number of Beds _____

## TEST ORDER INFORMATION *(required)*

Select desired tests below and provide anticipated volumes; alternatively append relevant test request form(s) with volumes.

☐ Toxicology _____ ☐ Infectious Disease _____ Frequency_____

## EXPECTED PAYER MIX *(required)*

HMO: Aetna ____ BC/CS Anthem ____ Cigna ____ Humana ____ Other ____

PPO: Aetna ____ BC/CS Anthem ____ Cigna ____ Humana ____ Other ____

Medicare: _____ Medicaid: _____ *(specify state)* Managed Medicare/Medicaid: _____ Workman's Comp: _____

## PHYSICIAN INFORMATION *(required)*

| Physician Name (Last, First) | Specialty | National Provider ID No. (NPI) | Phone No. | Email Address |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

## Approved Person(s) to have access to Results Report and Web-Portal (required)

| Name (Last, First) | Phone No. | E-mail Address |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

## ACCOUNT REQUESTS *(required)*

Reporting Preference

□ Web Portal □ Fax* □ EMR/EHR Interface (future): _____ *(specify)*

** NGL requires that clients supply us with the access phone number of a physically secured FAX machine and assumes responsibility that access to that machine is restricted to the physician and staff members to prevent the unauthorized release of PHI.*

Specimen Pick Up Frequency

□ Daily □ Weekly □ Other: _____ *(specify)*

## Additional Request/Instructions

***I hereby certify that the above information given are true and correct as to the best of my knowledge. By signing below, I authorize NextGen Labs to provide report and result access to the aforementioned individuals.***

Authorized Representative *Full* Name Authorized Signature Date