"NEW PATHOLOGY CLIENT INFORMATION FORM"

"A Center of Excellence"
Advanced Clinical Laboratories
"Focusing on Toxicology, Clinical and Anatomic Pathology"

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Long Beach, CA 90806
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Account Rep.: _____

Date Submitted: _____/_____/_____

CLIENT/FACILITY/CLINIC INFORMATION

TYPE: ☐ PRIVATE, ☐ FQHC, ☐ NON-PROFIT, ☐ RESEARCH

FACILITY/CLINIC NAME: _____

ADDRESS: _____ CITY: _____ STATE:___ ZIP: _____

TEL: (_____) _____-_____ FAX: (_____) _____-_____ GROUP NPI #: _____

PROVIDER(s) INFORMATION

(1) NAME: _____

Specialty:_____ Degree: _____

NPI #_____ CA LIC: _____

Email: _____

(2) NAME: _____

Specialty:_____ Degree: _____

NPI #_____ CA LIC: _____

Email: _____

(3) NAME: _____

Specialty:_____ Degree: _____

NPI #_____ CA LIC: _____

Email: _____

(4) NAME: _____

Specialty:_____ Degree: _____

NPI #_____ CA LIC: _____

Email: _____

DAYS OF OPERATION: ☐ M, ☐ T, ☐ W, ☐ TH, ☐ F, ☐ SAT, ☐ SUN

HOURS: _____ to _____ _____ to _____ _____ to _____

OFFICE CONTACT(s):_____ _____

LOCK BOX: ☐ YES ☐ NO BLDG. CLOSES ____:____

LOCATION of Lock Box:

_____

PICK UP: ☐ M, ☐ T, ☐ W, ☐ TH, ☐ F, ☐ S, ☐ SU,
☐ ROUTINE ☐ ON CALL Hour:_____
Drop Off Cases/Slides: ☐ M, ☐ T, ☐ W, ☐ TH, ☐ F, ☐ S, ☐ SU,
Hour:_____ GATE KEY ☐ YES ☐ NO

REPORT TYPES: ☐ FINAL REPORTS REPORT DELIVERY: ☐ FAX ☐ BY COURIER

☐ EMR NAME:_____ E-Fax #: (_____)_____-_____

☐ WEB ACCESS: USERNAME: _____ (Must be 6 to 10 characters (letters and numbers) no punctuation)

PASSWORD: _____ (Must be 6 to 10 characters (letters and numbers) no punctuation)

ESTIMATED MONTHLY SPECIMEN NUMBERS:_____ _____ _____

CUSTOM PANELS NEEDED ☐ YES ☐ NO
(Please itemize tests in the panels or attach a sample result):

_____

_____

SPECIAL INSTRUCTIONS: _____

_____

_____

NUMBER OF REQS/FORMS to PRINT:

Cytology/General Pathology:	_____
Dermatopathology:	_____
Genitourinary:	_____
Gastroenterology	_____
Histology Processing:	_____
Immunohistochemistry:	_____
Special Stains:	_____

BILL TYPE:

☐ MEDICAID

☐ MEDICARE

☐ MEDI-MEDI

☐ PRIVATE/PPO

☐ PATIENT

☐ HMO

☐ IPA:

1-_____

2-_____

3-_____

SERVICE START DATE:_____/_____/_____

Billing Instruction

(Please always, remember to attach legible copies of front & back of the insurance cards).

For Lab Use Only

CLIENT ID# _____ DATE: _____

Username and Password issues: ☐ Yes ☐ No

PROCESSED BY: _____