Account #: _____

ACCOUNT SET-UP & VERIFICATION
DIAMED LABORATORY SERVICES

*(Please make sure to fill in information where there is a *)*

Today's Date: _____ * **Begin Date:** _____ *
Client Name: _____ *
Address: _____ *
Phone#: _____ * **Fax#:** _____ *
Email: _____ *

Abnormal/Critical Results

Contact: _____ * **Phone:** _____ *
After Hours: _____ * **Phone:** _____ *

Billing Information

Physician (1): _____ * NPI#: _____ *
Physician (2): _____ NPI#: _____
Physician (3): _____ NPI#: _____
Physician (4): _____ NPI#: _____
Medicare#: _____ Verified by: _____
License#: _____ Verified by: _____
UPIN #: _____ Verified by: _____
Medical#: _____ Verified by: _____
FBP or DBA: _____ City: _____ Expires: _____
Business llC#: _____ City: _____ Expires: _____
Fictitious Business Permit or DBA on file with California Medical Board

Required Pick-ups *

			CLOSED AT	
Mon		AT	M	M
Tue		AT	M	M
Wed		AT	M	M
Thu		AT	M	M
Fri		AT	M	M
Sat		AT	M	M
Sun		AT	M	M

LOCK BOXES REQUIRED? ☐ **Yes** ☐ **No** Number: _____

Notes/comments:

_____

Signed by: _____ * **Date:** _____ *

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