Prostatype Genomics

Account Setup Form

Return by:
Fax: (949)-297-3984
Email: customer.care@prostatypegenomics.com

PRACTICE (ACCOUNT) INFORMATION – If provider(s) practice at separate locations, please complete a separate form for each location

Practice/Institution Name		Office Contact	
Street Address		Email	Phone
City/State/Zip		Billing Contact (if different)	
Practice Phone	Practice Fax	Billing Email	Billing Phone

Report Delivery Preference - Check all that apply, emails will be sent via encryption software.

☐ Fax: HIPAA Compliant Fax No.:_____ ☐ Email address:_____

PATHOLOGY LAB –Primary lab where prostate biopsy specimens are held

Practice/Institution Name	Contact Name	
Street Address	City/State/Zip	
Email	Fax	Phone

Report Delivery Preference if pathology should also receive patient reports - Check all that apply, emails will be sent via encryption software.

☐ Fax: HIPAA Compliant Fax No.:_____ ☐ Email address:_____

HEALTHCARE PROVIDER INFORMATION - For additional providers, attach an additional form

Print Provider Name (First,Last,Credentials)	National Provider ID (NPI)	Provider's email
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(Continued) **HEALTHCARE PROVIDER INFORMATION** – For additional providers, attach an additional form		
Print Provider Name (First,Last,Credentials)	National Provider ID (NPI)	Provider's email
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INTERNAL USE ONLY

ACCOUNT MANAGER USE ONLY

Account Manager:	Date:

Initial Supply Order

No. of Kits:	Ship to: ☐ Practice ☐ Pathology Lab

CUSTOMER SERVICE USE ONLY

Account Number: