New Client Registration

Practice Information:

- If you check yes to using the portal for preferred report delivery method then you must complete the separate OLS Portal User Information Form

Ordering Physician Information:

- Must list all providers full name, NPI, and email

Practitioner Acknowledgment:

- Must print each physicians name on separate forms with the clinic name and then have each physician's signature on their individual form right below next to physician's signature

Practitioner Acknowledgment Authorizations:

- Each physician must print their full name, sign their name, and date

Note: Complete separate registration forms for each location.

Please send all completed forms to Enrollment@OptimumLabServices.com

Account Set-Up Form

Collector			
Name:		Collector Email:	

Consultant Information					
Entity Name:		Email:			
Consultant:		Phone:			
Address:				Consultant ID#:	

Practice Information							
Practice Name:				Specialty:			
Street Address:						# of Locations:	
City:				State:		Zip	
Phone:				Fax:			
Org. NPI #:				Tax ID#:			
Office Contact:				Email:			
Preferred Report Delivery Method:		Portal		Fax		Account ID#	
Start Date		# of Monthly Patients		Vendor Name/ID#			
Critical Value Contact Info:							

Desired Modalities & Projected Monthly Specimens					
Blood Wellness			Toxicology		
Wound Path			PGx		
Molecular UTI					
Payor Mix	**Aetna**	**BCBS**	**Cigna**	**Humana**	**United**
Percentage for Each					

Specimen Pick-Up Days & Times						
Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Daily
Time:	12:00-2:00	1:00-3:00	2:00-4:00	3:00-5:00	4:00-6:00	

Ordering Physician Information: Please print full provider name, title (MD/DO, etc)					
Provider:		NPI:		Email:	
Provider:		NPI:		Email:	
Provider:		NPI:		Email:	
Provider:		NPI:		Email:	
Provider:		NPI:		Email:	

Each of the parties represents and warrants to the other party in particular with respect to all protected health information (as that term is defined under the standards for Privacy of Individual Identifiable Health information 45 C.F.R. part 164) as amended from time to time, that it is a covered entity (and not a business associate of the other party) under the HIPAA Privacy Regulations and that it shall protect the privacy integrity, security, confidentiality and availability of the protected health information disclosed to, used by, or exchanged by the parties by implementing appropriate privacy and security policies, procedures and practice and physical and technological safeguards and security mechanisms, all as required by, and set forth more specifically in, the HIPAA Privacy Regulation and HIPAA Security regulation as each may be amended from time to time.

I hereby acknowledge that in association with
will perform drug testing, blood chemistry screening, and PGX testing for patients from my practice.

Physicians Signature:		**Date:**	

Practitioner Acknowledgment

I authorize the lab to perform testing on my patients from my practice as directed by the individual requisition forms.

I understand that it is my responsibility to determine the medical necessity of tests I have requested for the treatment and/or diagnosis of my patients. I agree to provide diagnosis codes, defined to the highest level of specificity, for each test that I order to confirm medical necessity and to enable the lab to bill effectively on my patient's behalf. I understand that the lab will be billing third parties for the tests I order using the CPT codes. I will provide signed written orders from the patient's medical records to the requesting party within 72 hours, if requested.

I understand that I can contact the lab's Clinical Consultant should I have questions regarding the appropriateness of tests ordered.

I understand that the lab reflects the views, recommendations and guidelines outlined in the CMS National Coverage Policy.

I understand that the Office of the Inspector General (OIG) has cautioned that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law.

Regarding Toxicology Testing:
I further understand that according to Medicare, "Confirmation of drug screens is indicated when the result of the drug screen is different than that suggested by the patient's medical history, prescribed medications, clinical presentation or patient's own statement."

In addition, routine confirmations of drug screens with negative results will not be covered by Medicare. Confirmatory testing is covered for a negative drug/drug class screen when the negative finding is inconsistent with the patient's medical history or current documented medication list.

AUTHORIZATION			
Physician Name:			
Signature:		Date:	
Physician Name:			
Signature:		Date:	
Physician Name:			
Signature:		Date:	
Physician Name			
Signature		Date	
Physician Name			
Signature		Date	

*Each Provider must sign a NCP for each Facility

Please send all completed forms to Enrollment@OptimumLabServices.com

Portal User Information Form

Practice Name:_____ Office Phone: _____

STAFF INFORMATION

1.

	FACILITY TO COMPLETE		OLS TO COMPLETE
Staff First/Last Name:		Login/Username	
Position/Title:		Assigned Password	
Email address:		User Initials	
Cell Phone Number:		User Role	
		Email Sent	

☐ **Check Box if you would like the above to have permission to SCRIBE on your behalf - (Provider's Initials)** _____

2.

	FACILITY TO COMPLETE		OLS TO COMPLETE
Staff First/Last Name:		Login/Username	
Position/Title:		Assigned Password	
Email address:		User Initials	
Cell Phone Number:		User Role	
		Email Sent	

☐ **Check Box if you would like the above to have permission to SCRIBE on your behalf - (Provider's Initials)** _____

3.

	FACILITY TO COMPLETE		OLS TO COMPLETE
Staff First/Last Name:		Login/Username	
Position/Title:		Assigned Password	
Email address:		User Initials	
Cell Phone Number:		User Role	
		Email Sent	

☐ **Check Box if you would like the above to have permission to SCRIBE on your behalf - (Provider's Initials)** _____

4.

	FACILITY TO COMPLETE		OLS TO COMPLETE
Staff First/Last Name:		Login/Username	
Position/Title:		Assigned Password	
Email address:		User Initials	
Cell Phone Number:		User Role	
		Email Sent	

☐ **Check Box if you would like the above to have permission to SCRIBE on your behalf - (Provider's Initials)** _____

5.

	FACILITY TO COMPLETE		OLS TO COMPLETE
Staff First/Last Name:		Login/Username	
Position/Title:		Assigned Password	
Email address:		User Initials	
Cell Phone Number:		User Role	
		Email Sent	

Comments:

Users approved by:_____ **Signature:**_____ **Date:** _____

Provider's Name (Printed) **Provider's Signature**

Office Use Only: Received by:_____ Date:_____ Entered By:_____ Date: _____

Please send all completed forms to Enrollment@OptimumLabServices.com

Optimum Lab Services

Supply Order Form

Qty	Description
	Tubes
	SST (Yellow)
	SST (Tiger)
	Red
	Lavender (EDTA)
	Blue
	Royal Blue
	Grey
	Yellow (ACD-A)
	Green
	Black & Yellow
	Needles & Accessories
	25 gauge
	23 gauge
	21 gauge
	Needle holders
	Bandages
	Alcohol swabs
	Gauze
	XS gloves
	S gloves
	M gloves
	L gloves
	XL gloves
	Labels
	Small specimen bags
	Large specimen bags
	Serum/Plasma Transfer tubers

Qty	Description
	Packaging Supplies
	Biohazard sharp containers
	UPS shipping supplies
	Fedex shipping supplies
	Cytology/Histology Supplies
	Urine containers
	Sterile urine cups
	Stool culture
	Thin preps
	Blood culture bottles
	Microbology Supplies
	Culture swabs
	Ova/Parasite packs
	Occult blood packs
	Optima kit
	Toxicology
	Urine cup w/ temp strip
	Oral fluid swabs
	Toxicology requistions
	General
	General test requistions
	Printer ink/toner