Optimum Lab Services

MedRx Medication Reconciliation

Instructions for Enrollment

There are 2 pages contained in this Enrollment Packet which need to be completed to enroll for MedRx. Please submit completed documents in a PDF to Enrollment@OptimumLabServices.com

Lab Account Set-Up Form – *Setup Account to order MedRx Tests* (2 pages)
Please complete each field on all pages. Please provide best phone number (back-office, cell) to reach the Office Manager or contact person for practice.

Page 1 – Complete Form and provide Authorized Facility Signature

Page 2 – Obtain Signatures from each Provider

Onboarding Process

1. Facility completes enclosed forms *(listed above).*
2. Facility will receive a welcome email from OLS.
3. Facility will receive an initial supply of Test Kits, shipping bags and labels from Lab.
4. Facility will receive Reports Portal login information from the Lab.

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Lab Account Set-Up Form (pg 1)

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

Facility Information							
Facility Name:							
Type of Facility (hospital, home health agency, practice, etc.)		Type of Practice (pain, ortho, etc.)					
Street Address:		# of Locations:					
City:		State:		Zip			
Practice Phone:		Fax:					
Org. NPI #:		Tax ID#:					
Office Contact:		Email:					
Preferred Report Delivery Method:	Portal		Fax		Account ID#		
Start Date:		# of Monthly Patients		OM Phone:			

Projected New Monthly Patients						
Medication Reconciliation	Anticipated Monthly Samples (numeric value)					
Payor Mix	**Aetna**	**BCBS**	**Cigna**	**Humana**	**United**	**Medicare**
Percentage for Each						

Specimen Pick Up Days & Times						
Day:	Mon	Tues	Wed	Thurs	Fri	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 #1		NPI:		Email:	
Provider #2:		NPI:		Email:	
Provider #3:		NPI:		Email:	
Provider #4:		NPI:		Email:	
Provider #5:		NPI:		Email:	
Provider #6		NPI:		Email:	
Provider #7		NPI:		Email:	
Provider #8		NPI:		Email:	
Provider #9		NPI:		Email:	
Provider #10		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.

Authorized Signature:		**Date:**	

Please send all completed forms to Enrollment@OptimumLabServices.com

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Practitioner Acknowledgment (pg 2)

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.

AUTHORIZATION			
Provider #1 Name:			
Signature:		Date:	
Provider #2 Name:			
Signature:		Date:	
Provider #3 Name:			
Signature:		Date:	
Provider #4 Name			
Signature		Date	
Provider #5 Name			
Signature		Date	
Provider #6 Name			
Signature		Date	
Provider #7 Name			
Signature		Date	
Provider #8 Name			
Signature		Date	

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