Progress Medical

Health is Precious-Protect it!

Doctor Office Registration Form

(Please fill out all areas and return to representative at your scheduled meeting)

Practice name | Practice NPI | *Clinical specialty*

Practice phone xxx-xxx-xxxx | *Practice fax xxx-xxx-xxxx* (for sending Patient Health Information)

Practice address | *City* | *State* | *Zip*

Primary Contact person | *Contact phone* | *Contact email* | *Position*

Secondary *Contact person* | *Contact phone* | *Contact email* | *Position*

Clinic Support Staff

Name (first name, last name) | Email | Position (collector / lab tech / MA)

Name (first name, last name) | Email | Position (collector / lab tech / MA)

Providers

Signature confirms your request for enrollment

Name (title, first name, last name) | Email | NPI # | Signature

Name (title, first name, last name) | Email | NPI # | Signature

Name (title, first name, last name) | Email | NPI # | Signature

Name (title, first name, last name) | Email | NPI # | Signature

Pharmacist Name (first name, last name) | Email | NPI # | Signature

Clinic Payor Mix

% Medicare	% Tricare	% Medicaid *	% Commercial *	% Worker's Comp	% Self Pay	% Clinic Bill

*Specific Medicaids: _____ *Specific Commercial Payors:_____

Hours of Operation

Indicate Collection Days:	Open Time	Close Time	Blood Collections?	Desired UPS Pick-Up Time	Indicate Collection Days:	Open Time	Close Time	Blood Collections?	Desired UPS Pick-Up Time
Monday					Thursday				
Tuesday					Friday				
Wednesday					Saturday				