heliosdx.com/labs

Date Submitted: _____/_____/________
Desired Start Date: _____/_____/________

Please send completed form to bmccombs@heliosdx.com

LABORATORY SERVICES REQUESTED

Check at least one:

☐ Allergy (est. vol. _____) ☐ PCR - UTI, RPP, COVID, Women's Health, STI, Wound (est. vol. _____) ☐ Toxicology (est. vol. _____)

SALES/DISTRIBUTORSHIP INFORMATION

Sales Rep: ______________________ Sales Rep Phone Number: ______________________

Distributor Group: ______________________

CLINIC/PRACTICE INFORMATION

Legal Clinic/Practice Name: ______________________

Clinic Specialty: ☐ Pain ☐ Family Practice ☐ OB/Gyn ☐ Psych ☐ Other ______________________

Street Address: ______________________

Suite/Apt/Unit: ______________________

City: ______________________ State: ______ Zip: ____________

Telephone Number: ______________________ Fax Number: ______________________

Office Contact: ______________________ Email: ______________________

Supplies Contact: ______________________ Email: ______________________

PROVIDER INFORMATION

Please list all clinic/practice providers:

☐ MD ☐ PA ☐ NP Name: ______________________ NPI#: ______________________

☐ MD ☐ PA ☐ NP Name: ______________________ NPI#: ______________________

☐ MD ☐ PA ☐ NP Name: ______________________ NPI#: ______________________

☐ MD ☐ PA ☐ NP Name: ______________________ NPI#: ______________________

If you need additional space, please attach a separate sheet of paper.

REPORTING

☐ Fax: ______________ ☐ Portal - **Yes / No** ☐ Email: ______________________

Rejection Notification ☐ Portal ☐ Email: ______________________

Please send completed form to bmccombs@heliosdx.com

For further information or instruction please call 423.206.2299

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