OMNIHEALTH DIAGNOSTICS
2211 Century Center Blvd, Suite 110 Irving, TX 75062
Phone 972.887.3444 | Fax 972.887.3443
CLIA# 45D2089485 | Laboratory Director: Luisa Florez M.D.
www.OmniHealthDX.com

Enrollment Information Form

Internal Use Only:
Sales: _____ CSS: _____

Site ID: _____

Account Information			
Practice Name		Phone	HIPPA Compliant Fax
Address		Email	
City	State Zip	Account Type	

Contact Information	
Primary Contact Name	Ordering Physician Name
Primary Contact Phone Number	Ordering Physician NPI
Account NPI (if applicable)	CLIA Number (if applicable) Pecos ☐ Yes ☐ No

Account Startup Survey

Testing Services Requested, Estimated Monthly Volume

☐ Toxicology _____ ☐ Cardiac _____ ☐ CGx _____ ☐ OTHER _____

☐ PGx _____ ☐ RPP _____ ☐ OTHER _____ ☐ OTHER _____

What is the Carrier Mix?

Aetna:	%	BCBC:	%	Cigna:	%	Humana:	%	Medicaid:	%	Medicare:	%
UHC:	%	Client Pay:	%	Self Pay:	%	HMO:	%	Workers Comp:	%	Auto:	%
All Inclusive Contracts:	%	Other: _____	%	NOTES: _____							

By signing below, I certify that the information above is accurate. What is the desired start date? _____/_____/_____

Office Manager Name _____

Office Manager Signature _____ Date: _____/_____/_____

OmniHealth Account Representative Name _____

OmniHealth Account Representative Signature _____ Date: _____/_____/_____

NOTES

Please complete, sign and email to enrollment@omnihealthdx.com
***Please use one form for each individual location**

Office Approval (for internal use only):
OmniHealth Executive Name: _____ Signature: _____ Date: _____/_____/_____

OmniHealth Executive Name: _____ Signature: _____ Date: _____/_____/_____

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Provider Acceptance of Responsibility - Signature Log

Facility Name ____ **Date** _____ / _____ / _____

My signature below serves as verification that the signing provider will ensure that any and all laboratory tests ordered are ordered under my authorization and are medically necessary to ensure patient compliance with the therapy I have prescribed. I am responsible to notify the testing laboratory when I no longer serve as the ordering physician for this account.

PROVIDER SIGNATURE RECORD

Provider Name	Signature	NPI Number (required)
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other
______________________ (please print)	______________________ Pecos Enrolled: Yes ☐ No ☐	☐☐☐☐☐☐☐☐☐☐ ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Other

Note: I understand and hereby acknowledge that I will only order tests that I believe to be medically necessary to ensure patient compliance with the therapy that I have prescribed. The Office of Inspector General (OIG) also takes the position that a provider who orders medically unnecessary tests for which Medicare reimbursement is claimed, may be subject to civil penalties.

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Omni Direct Login - Information Needed

Facility To Complete (please print)

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________

(Select One) ☐ Provider ☐ Staff Member

Name (First & Last): ______________________________ Email: ______________________________