OMNIHEALTH DIAGNOSTICS

1840 N Greenville Ave Ste 176, Richardson, TX 75081
Phone 972-887-3444 | Fax 972-887-3443
www.OmniHealthDX.com

ACCOUNT REGISTRATION FORM

☐ NEW ACCOUNT REGISTRATION

☐ UPDATE EXISTING ACCOUNT

ESTIMATED START DATE: ______________________

PRACTICE INFORMATION

Practice Name	Practice Phone	HIPPA Compliant Fax

Street Address	Apt/Suite #	City	State	Postal Code

PRACTICE PRIMARY CONTACT INFORMATION

Practice Primary Contact Name	Practice Primary Contact Phone	Practice Primary Contact Email Address

ORDERING PHYSICIAN INFORMATION

Ordering Physician Name	Pecos Enrolled?	Ordering Physician NPI #
	☐ Yes ☐ No	☐☐☐☐☐☐☐☐☐☐

ACCOUNT STARTUP SURVEY

Enter Estimated Monthly Volume

PGx: __________ Toxicology: __________ Blood: __________

MOLECULAR

UTI: __________ Wound: __________ Fungal: __________ Vaginitis: __________ STI: __________ RPP: __________

NEXT-GEN SEQUENCING

CGx: __________ Cardio-Pulmonary: __________ Diabetes Predict: __________ Eye Disorder: __________

Neurological Disorder: __________ Thyroid Disease: __________ Primary Immunodeficiency: __________

PAYOR MIX

Enter Estimated % for Each Carrier

Commercial: __________ Medicaid: __________ Medicare: __________ Cash: __________

INTERNAL NOTES

OMNIHEALTH ACCOUNT REPRESENTATIVE INFORMATION

OmniHealth Account Representative (Print Name): ____

Email: ____ Phone: ______________________________

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PROVIDER ACCEPTANCE OF RESPONSIBILITY

PRACTICE INFORMATION

Practice Name

Street Address | Apt/Suite # | City | State | Postal Code

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 Officer of Inspector General (OIG) also takes the position that a provider who orders medically unecessary tests for which Medicare reimbursement is claimed, may be subject to civil penalties.

PROVIDER INFORMATION

Provider Name (First and Last) | Pecos Enrolled? ☐ YES ☐ NO | Credentials ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ OTHER

NPI # ☐☐☐☐☐☐☐☐☐☐ | Email | Phone

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PROVIDER ACCEPTANCE OF RESPONSIBILITY CONT'D

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PORTAL LOGIN INFORMATION

PRACTICE INFORMATION

Practice Name

Street Address	Apt/Suite #	City	State	Postal Code

FACILITY TO COMPLETE

Name (First and Last) — Select One: ☐ PROVIDER ☐ STAFF MEMBER
Email

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Email

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