

ACCOUNT REGISTRATION FORM

NEW ACCOUNT REGI	ISTRATION					
UPDATE EXISTING AC	CCOUNT			ESTIMATED START D	ATE:	
PRACTICE INFOR	RMATION					
Practice Name			Practice Phone	HIF	PPA Compliant Fax	
Street Address		Apt/Suite #	City	Sta	te Postal Code	
<u> </u>						
PRACTICE PRIM/ Practice Primary Contact	ARY CONTACT INFO	RMATION Practice Primary Con	tact Phone Practic	ce Primary Contact Email Addre	ss	
	SICIAN INFORMATION	N				
Ordering Physician Name	2		Pecos Enrolled?	Ordering Physician NPI	#	
			∐Yes ∐ No			
ACCOUNT STAR	TUD CUDVEV					
ACCOUNT START	TUP SURVEY					
Monthly Volume	PGx:	Toxico	logy:	Blood:		
		<u>MC</u>	<u>DLECULAR</u>			
UTI:	Wound:	Fungal:	Vaginitis:	STI:	RPP:	
		NEVT (SEN SEQUENCING			
		NEXT-0	GEN SEQUENCING			
CGx:	Cardio-Pul	monary:	Diabetes Predict	: Eye	Disorder:	
Neurological Disorder:		Thyroid Dis	sease:	Primary Immunodef	ary Immunodeficiency:	
PAYOR MIX						
Enter Estimated %	Commercial:	Medicaid	: l	Medicare:	Cash:	
for Each Carrier		medicald	·			
INTERNAL NOTE	:S					
OMNIHEALTH AC	COUNT REPRESENT	ATIVE INFORMATION	ON			
OmniHealth Account	Representative (Print Nar	ne):				
		,				
Email:				Dhono		



PROVIDER ACCEPTANCE OF RESPONSIBILITY

PRACTICE INFORMATION			
Practice Name			
Street Address	Ant/Cuito #	City	State Postal Code
Sileet Address	Apt/Suite #	City	State Postal Code
	About I haliance to be made		eticut compliance with the thousand their liver are evided. The Office
			atient compliance with the therapy that I have prescribed. The Officer ledicare reimbursement is claimed, may be subject to civil penalties.
PROVIDER INFORMATION			
Provider Name (First and Last)			Outdoutists
Flovide Name (First and Last)		Pecos Enrolled?	Credentials
NPI#	Email	☐YES ☐ NO	☐ MD ☐ DO ☐ PA ☐ ARNP ☐ OTHER Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		☐YES ☐ NO	☐MD ☐DO ☐PA ☐ARNP ☐OTHER
NPI#	Email		Phone
Provider Name (First and Last)		Danas Essallado	Cundoutiala
Flovider Name (First and Last)		Pecos Enrolled?	Credentials ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ OTHER
NPI#	Email	YES NO	☐ MD ☐ DO ☐ PA ☐ ARNP ☐ OTHER Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		YES NO	☐MD ☐DO ☐PA ☐ARNP ☐OTHER
NPI #	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
NDL#	Funcil	YES NO	MD DO PA ARNP OTHER
NPI#	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
·		YES NO	□MD □DO □PA □ARNP □OTHER
NPI#	Email		Phone



PROVIDER ACCEPTANCE OF RESPONSIBILITY CONT'D

PRACTICE INFORMATION			
Practice Name			
Chrosek Address			Double Code
Street Address	Apt/Suite #	City	State Postal Code
			ent compliance with the therapy that I have prescribed. The Officer
of Inspector General (OIG) also takes the position that a provider	who orders medically une	cessary tests for which Med	icare reimbursement is claimed, may be subject to civil penalties.
PROVIDER INFORMATION			
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		YES NO	MD DO PA ARNP OTHER
NPI #	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
Frovider Name (First and Last)			
		YES NO	MD DO PA ARNP OTHER
NPI#	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
,			MD DO PA ARNP OTHER
NPI#	Email	☐ YES ☐ NO	Phone
	Elliali		Filone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		YES NO	☐MD ☐DO ☐PA ☐ARNP ☐OTHER
NPI#	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		YES NO	☐MD ☐DO ☐PA ☐ARNP ☐OTHER
NPI#	Email		Phone
Provider Name (First and Last)		Pecos Enrolled?	Credentials
		YES NO	☐MD ☐DO ☐PA ☐ARNP ☐OTHER
NPI #	Email		Phone



PORTAL LOGIN INFORMATION

PRACTICE INFORMATION				
Practice Name				
Street Address	A 410 i4 #	Site.	C+-+-	Postal Code
Street Address	Apt/Suite #	City	State	Postai Code
FACILITY TO COMPLETE				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
(1.10.1 2.10.1)				CTAFE MEMBER
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
N. (5)				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				



PORTAL LOGIN INFORMATION CONT'D

PRACTICE INFORMATION				
Practice Name				
Street Address	Ant/Cuito #	City	Stata	Postal Code
Street Address	Apt/Suite #	City	State	Postai Code
FACILITY TO COMPLETE				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
rame (not and East)			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
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Email				
Name (First and Last)			Select One	
Email			PROVIDER	STAFF MEMBER
Ellidii				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
ivalie (Filst aliu Last)			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
			PROVIDER	STAFF MEMBER
Email				
Name (First and Last)			Select One	
•			PROVIDER	STAFF MEMBER
Email			_	