DIACARTA

CLIA ID#: 05D2110800

Account Setup Form

INSTRUCTIONS

1. Please PRINT CLEARLY when providing required information to ensure proper processing.
2. Please return completed form to support@diacarta.com.

PART 1. ASSOCIATED CLIENT'S NAME (REQUIRED)

CLIENT NAME

PART 2. SALES REP INFORMATION (REQUIRED)

SALES REP LAST NAME | SALES REP FIRST NAME | MIDDLE INITIAL | SETUP DATE

STREET ADDRESS | PHONE NO. | FAX NO.

CITY | STATE | ZIP CODE | EMAIL ADDRESS

PART 3. PRIMARY FACILITY ACCOUNT INFORMATION (REQUIRED)

PRACTICE/CLINIC NAME | OFFICE MANAGER NAME

STREET ADDRESS | PHONE NO. | FAX NO.

CITY | STATE | ZIP CODE | EMAIL ADDRESS

PART 4. PHYSICIAN INFORMATION (REQUIRED)

	PHYSICIAN NAME (LAST, FIRST)	SPECIALTY	NATIONAL PROVIDER ID NO.(NPIN)	PHONE NO.	EMAIL ADDRESS
1					
2					
3					
4					
5					

PART 5. SECONDARY FACILITY ACCOUNT INFORMATION

PRACTICE/CLINIC NAME | OFFICE MANAGER NAME

STREET ADDRESS | PHONE NO.

CITY | STATE | ZIP CODE | EMAIL ADDRESS

PART 6. PHYSICIAN INFORMATION

	PHYSICIAN NAME (LAST, FIRST)	SPECIALTY	NATIONAL PROVIDER ID NO.(NPIN)	PHONE NO.	EMAIL ADDRESS
1					
2					
3					
4					
5					