

Facility Information			
Today's Date		Date To Begin Testing	
Hospital/ Facility Name*			
Hospital/Facility Address 1*		Shipping Address 1	
Address 2		Address 2	
City		City	
State and Zip		State and Zip	
Phone Number*	Fax Number*	Website	# Of Employees
CLIA Number		CAP Number	
Contact Information			
Contact Name*		Contact Title	
Contact Email		Phone Number*	
Assistant's Name		Referred By	
Physician Information			
(1)Physician Name*		NPI Number*	
(2) Physician Name		NPI Number	
(3) Physician Name		NPI Number	
Test Interests			
Test Type(s)	Oligo BAC	Sample Type(s) Prenatal POC	Oncology Other:
Level of Service		Global Tech Only Program	
Direct Bill Customers Only- Invoice Instructions			
*We acknowledge that your terms of payment are 30 days from date of invoice. Initial: Date:			
Accounts Payable Contact*		Phone Number*	
AP Contact Email*			
Billing Address*			
City, State, and Zip			
CMDX Use Only			
			Client ID #

*Required for client setup

Please fax this completed form back to Client Services @ (949) 753-4725

Information collected on this form is used solely for the purpose of the CMDX Virtual Information Portal (VIP). This information will be handled and stored in accordance with HIPAA guidelines and will not be sold or used for other reasons.

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