New Account Setup Form

email completed form to: clientservices@combimatrix.com

Account Information

Facility Name | Date

Attention

Street 1

Street 2

City | State | Zip Code

Country | Website

Phone | Fax

Genomic Sales Specialist Name | Territory

Shipping Address*

◯ Same as facility address

Attention

Street 1

Street 2

City | State | Zip Code

Country

* All reports are automatically faxed to indicated number & 1 hard copy is mailed to indicated address. To change fax and mail preferences, indicate in Special Handling Comments. Separate form must be completed for VIP (online reports) set up.

Special Handling Comments (List any special requests or client specific instructions)

Contact Information

Primary Contact | Title

Phone | Email

Genetic Counselor Contact | Title

Phone | Email

Test Information

Specialty

◯ Prenatal ◯ Products of Conception ◯ Pediatric ◯ Oncology

Test Volume Per Month

_____BAC Array _____Chromosomes _____FISH _____POC

_____Oligo Array Other:_____

Level of Service: ◯ Global ◯ Tech Start Date:_____

Physician Information

Physician name | NPI

Physician name | NPI

Billing Information

Payor Mix (Total must be 100%)

_____ Direct Bill** _____Private Insurance

_____ Medicaid _____Patient Pay

_____ Medicare

Billing Contact Name | Title

Phone | Email

**Billing address must be provided for Direct Bill Accounts.

◯ Billing address is the same as shipping address

Attention

Street 1

Street 2

City | State | Zip Code