

INDUSTRY LAB DIAGNOSTIC PARTNERS



Facility Set-up Form

Facility Name: _____ Preferred Start Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone # _____ Fax # _____

Name of Key Contact: _____

Email Address: _____

Second Key Contact: _____

Email Address: _____

Does facility have a Fed Ex account number? Yes ___ or No _____ **(Your facility will not be charged for any ILDP pickups however we must have an account number to schedule your pickups. If you don't have a FedEx account number, we will establish one that is tied only to the ILDP account.)**

What are the preferred FedEx pickup days and times? _____

Reporting Preferences

I would like to receive my results via: Fax _____ Online _____

How many requisitions do you submit per week for confirmation? _____

Physicians/Provider Name & NPI

1. _____

2. _____

3. _____

4. _____

(Note: If more physician/provider names and NPIs, please provide a second form.)

Sales Rep Name: _____ Email: _____

Phone: _____

I hereby acknowledge that ILDP will perform drug testing on patients from this practice as indicated on individual patient ILDP requisition forms.

Authorized
Signature: _____ Date: _____