



Tel: 631-676-3784 Fax: 631-676-3776

Physician Facility Enrollment Form

**PRACTICE/FACILITY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

**PHYSICIANS:**

\_\_\_\_\_ NPI \_\_\_\_\_

\_\_\_\_\_ NPI \_\_\_\_\_

\_\_\_\_\_ NPI \_\_\_\_\_

Patient Billing Contact: \_\_\_\_\_

Test to be interpreted and billed by: \_\_\_\_\_

Medical Contact: \_\_\_\_\_

**Physician Signature** \_\_\_\_\_

Representative Signature \_\_\_\_\_

Notes: