ProterixBio

Provider Enrollment Form

ProterixBio, Inc. CLIA #22D2189261
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Tel: (978) 901-6700 Fax: (978) 901-6639

Practice Information:

Practice Name: _____

Primary Address: _____

City _____ State _____ Zip _____

Telephone: _____ Fax: _____

Practice Type: □ Solo □ Single □ Other
□ Concierge Model □ Specialty Group
□ Partnership □ Multi-Specialty Group

Group NPI#: _____

Office Hours:

Monday		Tuesday		Wednesday		Thursday		Friday	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

Provider Information

Provider's First Name: _____ Middle Initial: _____

Provider's Last Name: _____ Physician's NPI #: _____

Provider's email address: _____

Provider's Specialty: _____ Board Certified? □Yes □No

License Number: _____ State: _____

Provider's sub-specialty: _____ Board Certified? □Yes □No

License Number: _____ State: _____

Additional Licenses: _____ State _____

Practice Manager Contact Information

First Name: _____ Last Name: _____

email address: _____

Phone Number: _____ Fax Number: _____

Billing Contact Information

First Name: _____ Last Name _____

Phone Number: _____ Fax Number: _____

email address: _____

Reporting Contact Information

First Name: _____ Last Name: _____

Phone Number: _____ Secured Fax Number: _____

email address: _____

Preferred Reporting method: □ Call □ Secured Fax

Projected Volume

of lab draws per week _____ # of patients per month _____

Tests to be ordered □ 19723 SARS-CoV-2 (RBD) IgG Antibody □ Venous Blood Draw □ Dry Blood Spot
□ 19710 SARS-CoV-2 (S1) IgG Antibody *(not available with Dried Blood Spot samples)*

Completed By:	Phone/Email:	Date: