



# DISPENSING NEW ACCOUNT SETUP FORM

DocRx Sales Rep(s):

Account Manager(s):

Rep Partnership: Y or N

Multiple Locations: Y or N If yes, how many locations:

## CLINIC INFORMATION:

- Dispensing - POC
- Dispensing - Collections \_\_\_\_\_%
- Dispensing - Factoring
- Dispensing - Billing Only \_\_\_\_\_%
- Durable Medical Equipment (DME) \_\_\_\_\_%

Clinic Name:

Clinic Address:

City:

State:

Zip Code:

Practitioner Name:

State License #:

DEA License #:

Organizational NPI #:

Individual NPI:

## CLINIC CONTACT INFORMATION

First and Last Name:

Title:

Email Address:

Phone Number:

Fax Number:

## ACCOUNTS PAYABLE CONTACT INFORMATION

First and Last Name:

Phone Number:

Email Address:

- (check if same as clinic address)

Address:

City:

State:

Zip Code:

## PLEASE ATTACH THE FOLLOWING ITEMS FOR ALL CLINIC ACCOUNTS:

- State Medical License(s)
- DEA License(s)
- HIPAA BAA
- Customer Agreement/Contract
- Repackager Application (if applicable)
- SureScripts Form (if applicable)

## REQUIRED FOR BILLING ACCOUNTS ONLY:

- Direct Deposit
- Check

Name of person that will be receiving Monthly Statements:

Email Address:

Phone Number:

Fax Number:

EMR Access: YES or NO \*If yes, please provide the following contact info for EMR Access:

Name:

Email Address:

Phone Number:

Name of person that will be receiving DocRx's request for missing billing info, if not providing EMR Access:

Email Address:

Phone Number:

Fax Number:

## IF BILLING ACCOUNT, PLEASE ATTACH THE FOLLOWING ITEMS:

- W-9 Form
- NCPDP Application
- Relay Health Site Registration Form
- DocRx Direct Deposit Form (if applicable)

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

Date: \_\_\_\_\_