

# Customer Account Initiation Form

## PHYSICIAN ACCOUNT INFORMATION

Physician Name

Physician ID # (i.e., state license number)

Office/Facility Name

Mailing Address

City

State

ZIP

Shipping Address (if different from mailing address)

City

State

ZIP

Primary Contact Name

Office Phone --

Fax -- Email Address \_\_\_\_\_

Capillary Blood Collection Pack     Venous Blood Collection Pack     One of Each

## PAYMENT INFORMATION

Party Responsible for Payment     Physician (Bill Credit Card)     Patient (Bill Credit Card)

Please email, mail, or fax to: **Customer Service**

Phadia Immunology Reference Laboratory

4169 Commercial Avenue

Portage, MI 49002

Phone: 800.346.4364, Option 1    Fax: 888.243.5214

Email: usdiag.cust.serv@phadia.com

## INTERNAL USE ONLY

Assigned Account Number \_\_\_\_\_ Initials \_\_\_\_\_

Representative Code \_\_\_\_\_

Comments \_\_\_\_\_



PHADIA IMMUNOLOGY  
REFERENCE LABORATORY

Center for Innovation

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**Phadia**

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