

Please print clearly and complete entire form. **Please note all fields on this form are required.**

INSTITUTION INFORMATION

Institution: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Country: _____
 Main Contact Name: _____ Phone: _____ Ext: _____
 Fax: _____ Email: _____

PRIMARY CONTACT FOR SPECIMEN OR TESTING ISSUES (clarification of order, sample issues)

First Name: _____ Last Name: _____ Department: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Country: _____ Phone: _____ Ext: _____
 Fax: _____ Email: _____

PRIMARY CONTACT FOR BILLING (submitting invoices, obtaining POs, billing questions)

First Name: _____ Last Name: _____ Department: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Country: _____ Phone: _____ Ext: _____
 Fax: _____ Email: _____

Contact for Billing (Additional Required Billing Information)

Does your institution require a PO in order to invoice? Yes No
 Is IntrinsicDx required to be set up as a vendor at your institution Yes No

If yes, please email all applicable paperwork and instructions to clientservices@intrinsicdx.com or fax to +1-858-459-7777.

New clients should complete this form and fax (+1-858-459-7777) or email (clientservices@intrinsicdx.com) prior to submitting the first test order. Following registration, the institution will be assigned an account number for future test orders, please include the account number in the account number section on the Laboratory Requisition Form to ensure accurate and timely billing. Please note that all tests will be billed to the institution.

Signature: _____ Date: _____
 Name: _____ Title: _____

For IntrinsicDx Use Only	
Account #: _____	Credit Limit: _____
Date: _____	Initials: _____