

INSTRUCTIONS

1. Please PRINT CLEARLY when providing required information to ensure proper processing.
2. Please return completed form to support@diacarta.com.

PART 1. ASSOCIATED CLIENT'S NAME (REQUIRED)

CLIENT NAME

PART 2. SALES REP INFORMATION (REQUIRED)

SALES REP LAST NAME

SALES REP FIRST NAME

MIDDLE INITIAL

SETUP DATE

STREET ADDRESS

PHONE NO.

FAX NO.

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PART 3. PRIMARY FACILITY ACCOUNT INFORMATION (REQUIRED)

PRACTICE/CLINIC NAME

OFFICE MANAGER NAME

STREET ADDRESS

PHONE NO.

FAX NO.

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PART 4. PHYSICIAN INFORMATION (REQUIRED)

PHYSICIAN NAME (LAST, FIRST)

SPECIALTY

NATIONAL PROVIDER ID NO.(NPIN)

PHONE NO.

EMAIL ADDRESS

1					
2					
3					
4					
5					

PART 5. SECONDARY FACILITY ACCOUNT INFORMATION

PRACTICE/CLINIC NAME

OFFICE MANAGER NAME

STREET ADDRESS

PHONE NO.

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PART 6. PHYSICIAN INFORMATION

PHYSICIAN NAME (LAST, FIRST)

SPECIALTY

NATIONAL PROVIDER ID NO.(NPIN)

PHONE NO.

EMAIL ADDRESS

1					
2					
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4					
5					