Capture Diagnostics, LLC
Medical Provider Agreement

Capture Diagnostics - HIB01
CLIA No. 1202211451
Address: 1950 North King Street Honolulu, HI 96819 | Telephone: 808.953.8734 | Email: newaccounts@capturedx.com

1. Account Executive

1A. Name (First, Last)	1B. Phone Number	1C. Email Address

2. Primary Account Location Information

2A. Name (Practice/Facility/Clinic)	2B. Facility ID	2C. Office Contact Name	2D. Email Address

2E. Address (Practice/Facility/Clinic)	2F. City	2G. State	2H. Zip Code

2I. Phone Number	2J. After-hours Phone Number (For Critical Results)	2K. Fax Number

2L. Projected Start Date (MM/DD/YYYY)	2M. Type of Facility	2N. Number of Beds
	Detox/Rehab Hospital/Clinic Sober Living Home Other: ______________ (Specify)	

3. Test Order Information — 3A. Select desired tests below and provide anticipated number of samples per month

Toxicology ____________ Infectious Disease ____________

3B. Test Frequency

4. Expected Payer Mix

HMO: Aetna _____ BC/BS Anthem _____ Cigna _____ Humana _____ Other _____

PPO: Aetna _____ BC/BS Anthem _____ Cigna _____ Humana _____ Other _____

Medicare: _________ Medicaid: ____________(Specify State) Managed Medicare/Medicaid: _________ Workman's Comp: _________

5. Physician Information — Use a separate line to list each physician (required)

5A. Physician Name (Last, First)	5B. Specialty	5C. National Provider ID No. (NPI)	5D. Phone Number	5E. Email Address
1.				
2.				
3.				

6. Approved Person(s) to have access to Results Report and Web-Portal — Use a separate line to list each person (required)

6A. Name (Last, First)	6B. Phone Number	6C. Email Address
1.		
2.		
3.		

7. Account Requests

7A. Reporting Preference
Web Portal Email EMR/EHR Interface Request: ___________________ (EMR/EHR Name)

7B. Specimen Pick-Up Frequency
Daily Weekly Other: ___________________ (Specify)

7C. Additional Requests/Instructions

8. Signature — I certify that the above information given is true and correct to the best of my knowledge. By signing below, I authorize Capture DX/HIB01 to provide report and result access to the above listed individuals.

Authorized Representative Full Name: ______________________________ Authorized Signature: ______________________________ Date: ______________