Viracor | Eurofins Clinical Diagnostics

ACCOUNT SET-UP FORM

Client Name: ____

Primary Contact Information			
Contact for Testing Inquiries:			Title:
Main Address:			
Phone:	Fax:		Email:
Contact for Testing Inquiries:			Title:
Phone:	Fax:		Email:
General Phone # for Missing Information: Example: DOB, Collection Date, etc.			Phone:
Main Fax Results #:			
Additional Results Fax #:			
Additional Results Fax #:			
Purchasing Information			
Contact Name:			Title:
Phone:	Fax:		Email:
Purchase Order # Required	Yes:	No:	PO#
Accounts Payable Information			
Contact Name:			Title:
Phone:	Fax:		Email:
Billing Address:			
Contact Name on Invoice:			
Invoice Submission Preference (please select one):	Mailed:	Faxed:	Email:
Affiliated with other hospitals or integrated health network? ☐NO ☐YES	If Yes, please indicate other hospitals/integrated health network below: ______________________		

Viracor Eurofins Internal Use

Account Name: ______________________________ Sales Territory: ______________

Account Executive: ______________________________ Acct. #: ______________

Form Generated By (Internal Associate): ______________________________

It is necessary to have a one-time signature on file for all new clients. By signing below, the person as a representative of your organization agrees and guarantees payment. This form should be signed and faxed back to Viracor Eurofins before tests can be resulted.

Signature: ______________________________ **Date:** ______________

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