KEYSTONE LAB™
TRUSTED ANSWERS

SALES REP: _____

NEW ACCOUNT SET UP FORM

ACCT #: _____ **START DATE:** _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Secure Fax #: _____

Hours of Operation: M_____ T _____ W _____ TH _____ F _____ Hours:_____ Closed for Lunch from _____ to _____

Provider Name: _____ NPI #: _____

Provider Name: _____ NPI #: _____

Provider Name: _____ NPI #: _____

Provider Name: _____ NPI #: _____

Provider Name: _____ NPI #: _____

MAIN CONTACT: (Billing clarification assistance)

Name/Title:_____ Email:_____

Phone #: _____ Secure Fax #: _____

REPORTING OPTIONS: ☐Fax Results (secure fax required) ☐Portal**

**Name of user: _____ Email: _____

ADDITIONAL INFORMATION:

Specimen Type(s): ☐Urine ☐Oral Fluid Anticipated Monthly Volume: _____ Urine _____ Oral Fluid

Confirm Only ☐ (Clinic is using an immunoassay analyzer in-office and will bill for screening tests)

Screen & Confirm ☐ (Clinic is using an in-office collection device)

Shipping Method: ☐Courier Service ☐FedEx Overnight ☐UPS Overnight

Shipping Frequency: ☐On-Call Pick-Up ☐Scheduled Pick-Up

Select Day or Days for Scheduled Pick-Up: ☐Mon ☐Tue ☐Wed ☐ Thu ☐Fri

QUANTITY	ITEM	QUANTITY	ITEM
	MM Urine Requisition Forms		MM Flip Top Cups w/ Temp Strip
	MM Screw On Cups w/ Temp Strip		MM Oral Requisition Forms
	Quantisal w/ Specimen Bags		Specimen Bags (double pouched bags)
	Barcode Scanner		Barcodes & Seals
	Courier Shipping Supplies		UPS Shipping Supplies
	FedEx Shipping Supplies		Other:

AUTHORIZED FACILITY REPRESENTATIVE:

I hereby certify that all company program administrators will maintain drug test information reported as described in the above procedures in a confidential manner.

Printed Name _____ Signature _____ Date _____