New Account Registration & Rendering Provider Authorization

In order to provide seamless testing, processing, billing, and reporting the following information is required. All of the information you provide will only be used for professional purposes and kept in complete confidentiality. **A valid email address and cell phone number is required for each user accessing the portal.**

CLINIC INFORMATION

Clinic Name _____ Specialty _____

Address _____

Phone _____ Practice Manager _____

Weekly Patient Volume _____ Insurance Mix: Commercial _____ Medicare _____

PROVIDER INFORMATION

Provider Name _____ MD PA NP DO Gender: Female Male

Date of Birth _____ Place of Birth _____ SSN _____

Individual NPI _____ Cell Phone _____

Email _____

ALLERGY TECH INFORMATION

This is the person that will ship samples, pull reports, and order supplies from the online portal. They must provide a cell phone and email in order to access the portal.

Name _____ Title _____

Cell Phone _____ Email _____

Provider Acknowledgment

I hereby acknowledge, as the authorized signee of the above clinic, that our patient's lab samples will be sent to Bird Dog Pharma to perform blood allergy testing as directed by the individual patient test requisition form. I also acknowledge that Bird Dog Pharma will add me to their Federal and commercial insurance contracts, as a Rendering Provider.

Provider Name (print) _____ Title _____

Provider Signature _____ Date _____