Please complete as much as possible
It will enable us to customize our services geared to your practice

NCR # NCR1887 Fax 800.803.3455

Email chrismatt2008@gmail.com Phone 812-267-4610

Practice Account Information

In order to guide your office at every step of the on-boarding process, including logistics setup and report delivery, we will need the information outlined below as soon as possible to begin setting up your account.

Provider Tax ID/EIN #: _____

Group NPI #: _____

Is your practice a Corporation? _____ **If yes, please circle one:** LLC, PC, PA, PLLC, INC, CO.

Practice Name (as enrolled with insurance companies): _____

Do you have a DBA? _____ If yes, name: _____

Practice Address:

Street: _____

City: _____ **State:** _____ **Zip:** _____

County: _____

Pay-To Address (if different from practice address):

Street: _____

City: _____ **State:** _____ **Zip:** _____

County: _____

Main Office Phone: _____

Back Line/Private Line: _____

Fax: _____

Practice Email Address: _____

Website : _____

Provider E-mail Address: _____

Service Facility Addresses:

Location #1

Name_____

Address 1 _____

Address 2_____

City, State, Zip_____

Location #2

Name_____

Address 1 _____

Address 2 _____

City, State, Zip_____

Location #3

Name_____

Address 1 _____

Address 2_____

City, State, Zip_____

If there are additional service facilities, please list on a separate sheet.

Clinician / Physician Information:

1). Full Name and Degree: _____

License #: _____

Individual NPI #: _____ (Must be 10 digits)

2). Full Name and Degree: _____

License #: _____

Individual NPI #: _____ (Must be 10 digits)

3). Full Name and Degree: _____

License #: _____

Individual NPI #: _____ (Must be 10 digits)

4). Full Name and Degree: _____

License #: _____

Individual NPI#: _____ (Must be 10 digits)

5). Full Name and Degree: _____

License #: _____

Individual NPI#: _____ (Must be 10 digits)

6). Full Name and Degree: _____

License #: _____

Individual NPI#: _____ (Must be 10 digits)

Additional account set-up information & questions:

1. What is your anticipated date to begin sending samples to St. Jude Laboratories? _____

2. Please indicate the types of tests you would be sending to St. Jude:

   A. Covid-19 PCR Test ☐

   B. Molecular PCR :

   - Upper Respiratory RPP ☐
   - UTI ☐
   - STD ☐
   - Gastrointestinal ☐
   - Wound ☐
   - Womans Health ☐
   - Vaginitis ☐

   C. Toxicology :

   - Urine Screenings ☐
   - Urine Confirmations ☐

3. How would you want the test reports sent to you:

   Via email (100% HIPAA adherence) ☐
   You would like us to upload the reports to your EHR? ☐
   You would like access to our EHR so you can easily access the reports ☐

4. You would be required to send a copy of the patients insurance card (front & back) along with the requisition form and the sample.

5. Which Billing software do you use? _____

6. Anticipated volume for COVID -19 PCR tests per week _____

7. Do you use a separate software program for documentation? _____. If yes, which software do you

8. Who will be the SPOC (single point of contact) in your office to discuss sample pick up timings:

   Name _____ Phone # _____

9. Can we call your patients directly for information (i.e. Insurance ID#, COB)?_____

St. Jude Labs Service Agreement, terms, conditions and Acceptance

By submitting this on-boarding form, Practice and St. Jude Laboratories, LLC collectively referred to as "Parties" agree to the following:

1. St. Jude Laboratories, LLC is a CLIA-certified and duly licensed clinical laboratory located at 5525 Twin Knolls Rd Ste. 323, Columbia, MD 21045; herein referred to as Laboratory.

2. SUPPLIES: Laboratory shall provide Practice with sample collection kits at no charge, provided the Practice exclusively uses those kits to deliver/ship specimens to the Laboratory accompanied by a completed requisition or other order form and patient demographic/insurance information. Practice agrees to return the kits provided, to Laboratory, should it be determined that the kits will no longer be used, or pay for the cost of unused kits.

3. TURN-AROUND TIME. Laboratory shall utilize its best efforts to ensure that laboratory testing results are delivered to the Practice no more than forty-eight (48) hours from the time of Laboratory's receipt of the specimen ("Turn Around Time"). If there is a delay in results or additional testing is required to confirm the result which cannot be performed within the Turn-Around Time, Laboratory shall notify the Practice and provide a time-estimate of when such results will be delivered to the Practice.

4. INFORMATION PROVIDED BY LABORATORY: Laboratory will provide the final laboratory report ("Report or Reports") to the Practice for each test performed under this Agreement to the Practice via the Laboratory's information system or web portal, or as otherwise mutually agreed upon by the parties. The Report shall include at minimum the following: (1) Patient Name; (2) Patient date of birth; (3) date of collection; (4) date of report; (5) name of test(s) and test results.

5. INFORMATION PROVIDED BY PRACTICE: Practice shall supply, in a timely fashion, all demographic, insurance and any other information necessary for the Laboratory to be able to directly bill the applicable payer/s and collect for the services provided.

6. LAWS AND REGULATIONS: Parties represent and warrant each shall abide by all applicable Federal, State and local guidelines, statues, laws, regulations, rules, policies, standards and procedures now in effect or hereinafter enacted, including but not limited to, The Stark Law, Eliminating Kickbacks in Recovery Act of 2018 (EKRA), The Anti-Kickback Statute, and The Health Insurance Portability and Accountability Act (HIPAA).

7. INDEMNIFICATION: The Practice shall indemnify, defend and hold harmless the Laboratory against any losses, damages, claims, penalties and liabilities associated with the billing practices of the Practice, the Practice's use or disclosure of protected health information or other confidential information of patients. The Practice shall defend, hold harmless and indemnify the Laboratory against any and all claims, actions, liabilities, costs, fees, penalties and other expenses attributable to the acts or omissions of the Practice, its employees, contractors and agents and those of its customers and their employees, contractors and agents.

8. MATERIAL CHANGE: It will be the Practice's responsibility to inform the Laboratory immediately of any changes with any Authorized Agents, Physicians, change of addresses, licensures, or change of address and/or additional locations.

IN WITNESS WHEREOF, this Agreement has been duly executed as of the Effective Date

PRACTICE:

By: _____ Name: _____ Title: _____

LABORATORY: St. Jude Laboratories, LLC

By: _____ Name: HARMAN DHAWAN