



Account Update Request

Account Number:

MVL Doctor ID #

Please complete only those sections that require updating.

Additional comments:

Update Primary Account Information

<i>Primary Account Holder's Last Name</i>	<i>First Name</i>	<i>Initial</i>	<i>Credential</i>
<i>State or Provincial Professional License/Registration/Certification #</i>		<i>Specialty</i>	
<i>Practice/Clinic Name</i>			
<i>Street Address</i>			
<i>City</i>	<i>State or Province</i>	<i>Zip Code or Postal Code</i>	
<i>Telephone Number</i> ()	<i>FAX Number</i> ()		
<i>E-mail</i>			
<i>Shipping Address (if different from above)</i>			
<i>Billing Address (if different from above)</i>			

Update Additional Authorized Practitioners for Account Use

<i>First Name</i>	<i>Last Name</i>	<i>MI</i>	<i>Accreditation</i>	<i>State/Provincial License/Registration #</i>

Update Administrative Contacts

<i>Lab Contact</i>	<i>Telephone Number</i> ()	<i>Ext</i>	<i>E-mail</i>
<i>Office Contact</i>	()		
<i>Billing Contact</i>	()		
<i>Shipping Contact</i>	()		

Update Results Reporting (*How do you want to receive your results? Please choose one.*)

<input type="checkbox"/> MAIL	<input type="checkbox"/> FAX ()
<input type="checkbox"/> E-MAIL * E-mail Address :	



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Acct # _____

Billing Method

<input type="checkbox"/> PATIENT PREPAY	<i>By choosing "Patient Prepay", I or my patient will send payment in full with each test submission. If payment is not received, the patient will be contacted for payment and the results will not be released until paid in full. By choosing "Bill Practitioner", charges will be billed to my account, and I agree to pay all outstanding balances in full within 30 days of the statement date. I understand that all accounts are subject to credit review with approval, that credit limits may be established, and unpaid balances over 30 days are subjected to a monthly service charge of 1.5%. If an account balance becomes over 60 days past due, Meridian Valley Lab reserves the right to hold all results until the account is brought current.</i>
<input type="checkbox"/> BILL PRACTITIONER* <small>*Credit application Required</small>	

Credit Card Authorization

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> DISCOVER CARD
Card #: Expiration Date : Security Code:			
Name on Card:			
Cardholder Signature:			

*The undersigned hereby agrees to be responsible for payment and to comply with the terms listed above. Meridian Valley Lab is neither an insurance provider, nor a Medicare participating provider. **Patients cannot submit claims to Medicare**, but may submit to supplemental insurance companies. Meridian Valley Lab is not licensed in the State of New York and cannot ship test kits or results to the State of New York.*

I certify that I meet all state/provincial licensing/registration requirements and that I am authorized to order laboratory testing in my state/province.

.....
Signature

.....
Date

.....
Printed Name