Completed forms can be sent to:
E-mail: info@meridianvalleylab.com
Fax: 206-209-4211

Meridian Valley LAB

MVL Account ID#: _____

Account Update Request

Please complete only those sections that require updating

Comments

Update Primary Account Information

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

Update Additional Authorized Practitioners for Account Use (Add/Remove)

Add/Remove	*First Name*	*Last Name*	*MI*	*Accreditation*	*State/Provincial License/Registration #*

Update Administrative Contacts

Lab Contact	*Telephone Number* ( )	*Ext*	*E-mail*
Office Contact	( )		
Billing Contact	( )		
Shipping Contact	( )		

Update Results Reporting *How do you want to receive your results?*

☐ MAIL	☐ FAX ( )
☐ SECURE ONLINE PORTAL	*E-MAIL ADDRESS FOR ONLINE PORTAL:

Meridian Valley Lab
6839 Fort Dent Way Ste. 206, Tukwila, WA 98188
Tel 206.209.4200 · Toll-Free 855.405.TEST (8378) · Fax 206.209.4211
info@MeridianValleyLab.com

Completed forms can be sent to:
E-mail: info@meridianvalleylab.com
Fax: 206-209-4211

Meridian Valley LAB

MVL Account ID#: _____

Billing Method

☐ PATIENT PREPAY	*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 bought current.*
☐ BILL PRACTITIONER* **(Select One)* ☐ CC On File ☐ Credit Application	

Credit Card Authorization

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER CARD

Credit Card #: _____ Expiration Date: _____ Security Code: _____

Name on Card: _____

Cardholder Signature: _____

☐ **Charge Credit Card Monthly** ☐ **Charge Credit Card with Every Sample Received**

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

Meridian Valley Lab
6839 Fort Dent Way Ste. 206, Tukwila, WA 98188
Tel 206.209.4200 · Toll-Free 855.405.TEST (8378) · Fax 206.209.4211
info@MeridianValleyLab.com