UC DAVIS HEALTH | Department of Pathology and Laboratory Medicine

Lab Outreach Client Account Form

Referring Facility Name: (maximum 30 characters)

_____

Address:_____

_____

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

Billing Contact:

Name: _____

Address:_____

_____

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

Phone number: _____ **Fax:** _____

E-mail:_____

Authorized Approver:

Print Name:_____

Signature:_____ **Date:** _____

UC Davis ONLY

Client Bill – Register in Epic	UC Davis Health Lab Representative
Contract: Yes [ ] No [ ]	**Name:**_____
Discount:_____	**Phone:**_____
EAF Abbreviation:_____	**Email:**_____
Guarantor MRN:_____	**Date Requested:**_____