ENLOE
CLIENT SERVICES

Epic Acct# _____

GalenMD _____

eScreen _____

REQUEST FOR BILLING ACCOUNT

Date _____ CS Staff Name _____

Client/Business Name _____

Are you a Third Party Administrator? ☐ Yes ☐ No

- *If Yes,* who is your local Client _____

Contact Name _____

Phone _____ Fax _____

Email _____

Billing Address _____

Results contact name/phone _____

Billing contact name/phone _____

Service(s) Requested _____

Drug Screen Type _____

- Do you have an MRO? ☐ Yes ☐ No
- Who is your DER? ☐ Yes ☐ No
- How do you want drug screen resulted? _____
- Secure Fax _____ or EMAIL _____

Do you require special client forms (physical exam, fitness, authorization, etc.)? ☐ Yes ☐ No

- *If Yes,* please attach

Do you have an immediate need to schedule? ☐ Yes ☐ No

- *If Yes,* how many? _____

What is the expected annual volume of employees to be tested? _____