PHYSICIAN REGISTRATION FORM

REFERRING PHYSICIAN INFORMATION	1st Line Medical Rep:	
Name of Physician:	Medical Specialty:	
PHYSICIAN VERIFICATION (One Required)		
Date of Birth (mm/dd/yyyy): OR Year of Graduation from Medical School (yyyy):		
NPI #:	State Licensed In:	License#:
Practice Address:		
City:	State:	Zip:
Office Phone Number:	Office Fax Number:	
E-Mail address:		

Do you want the Sleep Studies interpreted by 1st Line Medical's interpreting physician on all orders? Yes _____ No _____

Who do you prefer to do billing for commercial services provided? 1st Line Practice

Do you want to designate an authorized individual in your office to handle communications regarding Prescribed Service? Yes_____ No _____

If Yes, Name:_____ Ext:_____ E-mail:_____

Would you like to be listed on our website referral page? Yes _____ No _____

If Yes, please specify link (if applicable):

_____

Physician Signature: _____ Date: _____

How did you hear about 1st Line Medical?

___Mail ____Fax ____Insurance ____Advertising ____Referral ____Paper/Article ____Representative

Fax Number: 800-918-7860 **Phone Number: 866-720-8080**