Provider Demographic / Collector Request Form

otogenetics® corporation

Provider Demographic Form

Practice Name *Contact* *Email*

Address *City* *State* *Zip* *Phone* *Fax*

SALES INFORMATION

Distributorship _____ Date _____ Sales Rep _____

Sales Rep Email _____

PROVIDER AUTHORIZATION

Providers should only order tests they deem medically necessary for the diagnosis and/or treatment of the patient. I authorize Otogenetics Corporation to perform testing on specimen collected from my patients, as indicated by my preferences detailed below. I understand that this provider preferred order will remain in effect until an updated form has been submitted to Mrmec l cŋaq Ampnmp_rym l . I also s l bcpqr_ l b r f_r◊ may change these preferences, on a case-by-case basis, by designating my testing preferences on a l Mrmec l cŋaq Ampnmp_rym l test requisition form.

Provider	Specialty	Provider NPI #	Provider Lic #	Signature
1				
2				

Requested Services

O Pharmacogenetic Testing
O DA3 Hereditary Hearing Loss Test
O Inherited Cancer Screening
O Pharmacogenetic Testing
O Cardiomyopathy Test
O Carrier Screening

Collector Request Form

Practice Name *Phone* *Fax*

Address *City* *State* *Zip*

Contact *Email* *Phone*

Representative Name