

## New Account Information

Practice Name	
Specialty	
Address	
City/State/Zip	
Office #	Fax #
Primary Contact/Email	

**Client To Do Task List: Provide**

<input type="checkbox"/>	Group NPI:	
<input type="checkbox"/>	Individual NPI:	
<input type="checkbox"/>	Tax ID(s):	
<input type="checkbox"/>	MD Name(s)	
<input type="checkbox"/>	PTAN- Group/Individual:	
<input type="checkbox"/>	Provider #s:	
<input type="checkbox"/>	EHR Access:	
<input type="checkbox"/>	Clearinghouse Name/PW:	
<input type="checkbox"/>	HIN#	

If no HIN#, please apply: [www.hibcc.org](http://www.hibcc.org) (can take up to 2 weeks to obtain-email once rcvd)

**Provide Payor Account Login( User Name / PW)**

<input type="checkbox"/>	Aetna	
<input type="checkbox"/>	Cigna	
<input type="checkbox"/>	UHN	
<input type="checkbox"/>	Tricare	
<input type="checkbox"/>	AARP	
<input type="checkbox"/>	TMHP	

**SSRx Responsibilities**

<input type="checkbox"/>	Check as task completed
<input type="checkbox"/>	Provide Vendor Applications – Retrieve From MDO and Submit (must have HIN#)
<input type="checkbox"/>	Signed Contract Received:
<input type="checkbox"/>	Infusion Days:
<input type="checkbox"/>	Chair Count:
<input type="checkbox"/>	Enter in WelInfuse
<input type="checkbox"/>	Secure/Train Infusion Nurse
<input type="checkbox"/>	Set-up Infusion Suite
<input type="checkbox"/>	Who will collect co-pays: _____
<input type="checkbox"/>	Obtained Signed Anaphylaxis Order(s)
<input type="checkbox"/>	Obtain Orders and Patient Schedule * As Applicable
	Oxygen Tank Present:    Yes    _____    No    _____
	Biohazard Account In Place: Yes    _____    No    _____
	Pulse Ox Preset:        Yes    _____    No    _____
	Crash Cart Present:    Yes    _____    No    _____

**Target Launch Date:** \_\_\_\_\_ **Launch Meeting Date:** \_\_\_\_\_

**Sales Executive:**