NEW MEDICAL PRACTICE

ACCOUNT INFORMATION

Products4Doctors
Email enroll@products4doctors.com
Fax 727-233-1190 Call or Text 727-999-3119

PRACTICE INFORMATION

Name of Practice: ____________________

Physical Address: ____________________

City: ____________ State: _____ Zip: ____________

Phone: ____________ Fax: ____________

Days and Hours of Operation: ❑ Mon _______ ❑ Tues _______ ❑ Wed _______ ❑ Thur _______ ❑ Fri _______

Days or Times Packages Cannot Be Received: ____________________

Primary Contact: ____________ Primary Contact Email: ____________

Shipping Contact: ____________ Shipping Contact Email: ____________

Billing Contact: ____________ Billing Contact Email: ____________

PRESCRIBER INFORMATION

Name: ____________ NPI # ____________ DEA # ____________

Name: ____________ NPI # ____________ DEA # ____________

Name: ____________ NPI # ____________ DEA # ____________

Name: ____________ NPI # ____________ DEA # ____________

❑ Check here if mid-level prescriber is working under a collaborative practice model and include both the mid-level and supervising physician's (MD, DO) provider identification numbers above.

BILLING INFORMATION

Tax ID: ____________

Name (as appears on card): ____________ ❑ Billing Address Same as Above

Physical Address: ____________________

City: ____________ State: ____________ Zip: ____________

Card #: ____________ Expires: ____________ Security Code: ____________

❑ Visa ❑ Master Card ❑ Discover ❑ American Express

____________________ ____________

SIGNATURE DATE

____________________ ____________

Print Name Here Job Title

By signing this form, I authorize Summit Allergy to charge all invoices directly to my credit card at the time of purchase. I understand no orders will be shipped until my credit card transaction is successful.

Scan and fax completed form to: (727) 233-1190 **or, email to** enroll@products4doctors.com

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