NRLBH
Powered by Atossa Genetics

New Provider Enrollment Form

Please complete the information below and return to your NRLBH account representative or

Fax: 1-888-314-6298 **Email: enroll@NRLBH.com**

Healthcare Provider:

Last name: _____ First Name: _____

Credentials: ☐MD ☐DO ☐ARNP ☐Other: _____ NPI #: _____

Practice Information:

Practice Name: _____ Specialty: _____

Phone: _____ Fax: _____

Shipping Address:

Street: _____

City: _____ State: _____ Zip: _____

Billing Address:

☐ Same as shipping address

Street: _____

City: _____ State: _____ Zip: _____

Office Contact:

Name: _____ Title: _____

Phone: _____ Email: _____

Online Report Access:

NRLBH provides a secure web portal to access your patients' results online. Please include an email address to receive login and password information.

Email to receive report notification: _____

Please create accounts for the staff listed below to allow access to my reports. I understand that by granting this permission, these individuals will have access to confidential health information contained in laboratory reports for my patients:

Name: _____ Email: _____

Name: _____ Email: _____

Healthcare Provider Signature		Date	

RepID: _____