LETTER OF AGREEMENT

Envision Healthcare Resources, LLC (d.b.a. Envision Clinical Laboratory) agrees to provide services to:

Organization:		
d.b.a.		
Tax ID (EIN) #:	Medicare #:	Physician NPI:
Authorized Agent:	Telephone contact: Email: Fax:	
Physical Address:		
Billing Address: check here if same as physical address: ☐		
Service Start Date:	Set up date:	
Specimen Pick Up Requirements Client will call ECL for pickup ☐ ECL will call client ☐ Schedule routine pickup (circle all that apply): M T W TH F		
Please provide approximate for each of the following: Client % Medicare % Medicaid % Private Ins. % Patient % HMO%		
Do you require in office phlebotomy service: Yes ☐ No ☐ If Yes, your office will be scheduled for phlebotomy service on: Day of Week: Approximate Time:		
The authorized signature below certifies that the client agrees to the terms and conditions printed on this agreement for both pages one and two. Authorized client signature: Date:		
Envision Healthcare Resources, LLC signature: Date:		