Premier Medical™
LABORATORY SERVICES

PHYSICIAN TEST REQUISITION AGREEMENT

MEDICAL RECORD EVIDENCE OF LABORATORY TEST ORDERS

As a practicing physician or non-physician practitioner, I requisition various laboratory tests from Premier Medical Laboratory Services ("PMLS"). In so doing, I understand that PMLS, by authority of CMS-1524-FC issued 11-28-11, does not require my personal signature on all Laboratory Test Requisitions, or on written confirmations of verbal requests for laboratory tests, which originate from my practice, but will, in addition, accept my staff members' signatures on both, upon my signing this Agreement.

I also understand that for every verbal request for a laboratory test(s) originating from my practice, PMLS requires written confirmation for the patient record, signed by either me or a staff member in my practice, within 10 days of the verbal request.

I acknowledge and affirm that every Laboratory Test Requisition and every written confirmation of a verbal request for laboratory tests, originating from my practice, whether signed by me or one of my staff members, is based on medical necessity for the individual patient, made pursuant to my direct order, which is noted in the patient's medical record, signed by me, and shall remain in my custody and control.

By signing this Agreement, I agree that should PMLS undergo an internal compliance audit or an external audit by any entity with auditing authority, and as a result, I am requested to provide medical record evidence regarding any order for a Laboratory Test Requisition or confirmation of a verbal request for laboratory test(s), originating from my practice, I will fully cooperate with PMLS, or the auditing authority, to furnish same, in a timely manner, as requested.

I further acknowledge and affirm that should I decide to revoke my staff's authority to sign Laboratory Test Requisitions or written confirmations of verbal requests for laboratory tests, I will notify PMLS of such decision, in writing, by email to Elizabeth Brown, Client Services Supervisor, at ebrown@vesselmedical.com.

Physician's Name (printed): _____

NPI#: _____

Physician's Practice Name (printed): _____

Physician's Signature: _____

Date: _____ Witness: _____