ANSERVE'S CUSTOMER INFORMATION FORM
Upon Completion, Fax Form to 973-915-6017
Phone 973-283-2000

PRACTICE NAME: _____

ADDRESS (**No P.O. Box #**): _____

_____
(City) (County) (State) (Zip)

BILLING ADDRESS (if different from above) _____

_____
(City) (County) (State) (Zip)

OFFICE MAIN PHONE # _____

PRIVATE OFFICE # _____ MAIN FAX # _____

PRIMARY CONTACT NAME _____

PRIMARY CONTACT E-MAIL _____

WEB-SITE ADDRESS _____

OFFICE HOURS:

Mon: _____ Tue: _____ Wed: _____Thurs: _____ Fri: _____ Sat: _____

What time do you want your daily recap? _____ Sent via Email or Fax? _____

Do you forward for lunch? _____ Is there an on-call schedule? _____

OFFICE MANAGER NAME _____ STAFF HOURS_____
CALL RELAY INSTRUCTIONS: (Page medical call, emergency calls, etc.)
_____
_____
_____
_____

MESSAGES DELIVERED VIA *(check all that apply)*
___FAX ___TEXT ___SECURE TEXT ___EMAIL ___PHONE CALL

TIME(S) OF DAY(S) TO BE SENT _____

COVERAGE NAMES & # _____

COVERAGE CHGS AT WHAT TIME _____

HOSPITAL AFFILIATION _____

REASON FOR LEAVING LAST SERVICE _____

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INDIVIDUAL PHYSICIAN INFORMATION *(fill this out for EACH physician we are answering for)*

Please include as much information as possible regarding your protocol.

PHYSICIAN NAME _____

CONTACT NUMBERS Please list number and circle preferred method.

1st: home, cell or text: ( )_____

2nd: home, cell or text: ( )_____

3rd: home, cell or text: ( )_____

4th: other ( )_____

DO YOU WANT HIPAA COMPLIANT TEXTING? _____

Please provide your email to create your password:_____

RELAY INSTRUCTIONS (Y/N)
Relay all medical/Emergency calls:_____ Refills: _____ Labs: _____

CONSULTS/NEWBORNS (Y/N)
Relay ALL at all times: _____
Relay ALL consults/newborns until 10pm then hold routines for 7am call out: _____

ADDITIONAL SPECIAL INSTRUCTIONS _____
_____
_____

ARE YOU AVAILABLE FOR NON-PTS AFTER HOURS? _____

SIGNATURE OF PERSON FILLING OUT FORM:

_____

TITLE : _____ DATE: _____

(rev. 7/2018)