Asteria Health	Customer Application

Physician/Practitioner Name	
Legal Name of Business	
Phone Number	
Fax Number	
Email (for order confirmations)	
Location Address	
Shipping Address ☐ Same As Location Address	

Is this facility part of a multi-facility practice or owned by a parent organization? **Yes** ☐ **No** ☐
If yes, attach additional Customer Application sheet(s) as needed with necessary information.

Days/Hours open for deliveries: (Orders ship via FedEx) **Time Zone:**

Mon. **Tue.** **Wed.** **Thu.** **Fri.**

State Medical License Number & Expiration: (must match Physician/Practitioner Name listed above)

Number: _____ **Expiration:** _____
Copy Attached? Yes ☐ ***Orders will not be processed until copy of current state license is received***

Physician/Practitioner DEA Number & Expiration: (must match Physician/Practitioner Name listed above)

Number: _____ **Expiration:** _____
Copy Attached? Yes ☐ ***Orders will not be processed until copy of current registration is received***

Business/Facility DEA Number & Expiration: (must match Business/Facility listed above)

Number: _____ **Expiration:** _____
Copy Attached? Yes ☐ ***Orders will not be processed until copy of current registration is received***

Additional persons approved to conduct business on this account: (Attach additional sheet if necessary)

Name Email Phone

1) _____

2)

Return completed form and all requested documents to info@asteriahealth.com or fax to (844)771-0505

Please allow 3 business days for review, approval and set up.
Call (855)771-0505 or email info@asteriahealth.com with any questions regarding account setup or this form.