PROVIDER INFORMATION
*****ALL INFORMATION ON THIS PAGE IS REQUIRED*****
Please print legibly or type, with all questions answered.

First Name _____ Middle _____ Last Name_____

DOB_____ Gender ____ Chiro School _____ Grad yr._____

SS# _____-_____-_____ Indiv. NPI (type 1) _____

List any language other than English in which you are fluent_____

Are you a State Association Member _____ (print association name)

E-MAIL: _____

Tax ID #: _____ Business NPI (type 2)_____

Primary Practice Name & Address: _____

_____

_____

County: _____

Mailing Address (P.O. Box)_____

Office Phone_____ Office Fax _____

Office Contact Name:_____ Title:_____

Office E-mail _____

*Check made payable to: _____

Malpractice Insurance Carrier_____ Expiration Date_____

Policy Number_____ Coverage Amount _____

Medicare Provider Number _____ UPIN Number _____

License #_____ License State _____ Exp. Date:_____

List all other states in which you **hold or have held** a license:_____

Do you have additional locations *Y/N_____ County:_____

Tax ID (if diff) #: _____ Add. Bus NPI (type 2) if dif_____

2nd Practice Name & Address: _____

_____

_____

2nd Office Phone _____ 2nd Office Fax _____

2nd Mailing Address (ie: PO Box)_____

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Trained _____ EFT (Dir Dep)_____ Auto _____y/n EDI _____