

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 _____

E-MAIL: _____

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

Primary Practice Name & Address: _____

County: _____

Mailing Address (if different) _____

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 # _____ Practice Management System _____

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) _____

- - - - -
Trained _____ EFT (ACH) _____ EDI _____ Auto _____ y/n Multiplan _____ y/n