

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 _____ Chiropractic School _____ Grad yr. _____

SS# _____ - _____ - _____ Individual 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 _____

Primary Office Tax ID # _____ Business NPI (type 2) _____

Primary Practice Name & Address _____

Mailing Address (P.O. Box) _____

Office Phone _____ Office Fax _____

Malpractice Insurance Carrier _____ Expiration Date _____

Policy Number _____ Coverage Amount _____

Medicare Provider Number _____ UPIN Number _____

License Number _____ License State _____ Expiration Date _____

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

Do you have additional locations *Y/N _____

Add. Office Tax ID # _____ Add. Business NPI (type 2) _____

Additional Practice Name & Address _____

2nd Office Phone _____ 2nd Office Fax _____

2nd Mailing Address (ie: PO Box) _____