Submit By E-Mail | Print Form

SOTERIA HEALTHCARE NETWORK®

INSTRUCTIONS:

Please Print Legibly & Fax Back To Fax #: (770) 455-4120

NOTE: If Your TIN Has Changed, You Should Also Complete & Attach A New W-9 Form With This Change of Address Form. Thank You.

SOTERIA HEALTHCARE PROVIDER locality form

(Please Complete If The Information Has Changed In The Last Twelve (12) Months)

PRACTICE information

If New Location/Address, Please Indicated The Date You Moved Into Your Practice:

Providers Name: Phone: - NPI:

Office Managers/CAs Name: Indiv. TIN:

Address: City: State:

Zip:

Fax:

# of CAs Employed: Front Office Back Office Other

Do You Have Massage Therapist(s) Employed: Yes No

(If Yes, Please list how many)

# of Massage Therapists: / Part-Time Full-Time

Do You Have More Than One Chiropractor At This Office Location? Yes No

(If Yes, Please List Names of ALL Doctors Practicing At This Location)

Please List Office Hours:

Mon. Tues. Wed. Thurs. Fri.

Sat. Sun.

PROVIDER directory information

E-Mail: @ Languages Spoken:

Office Web Site:

EQUIPMENT & facility information

On-Site X-Ray: Yes No If Yes, What Make:

State X-Ray Certification: Yes No Last Date Certified:

Model: Size Unit: KV: MA:

Year Manufactured: Table Bucky: Wall Bucky:

Type of Facility:

Free Standing Medical Building Office Building Storefront Other

Does Your Office Have Handicap Access? Yes No

Emergency (Urgent Care) Service: Yes No If Yes, By Whom:

24-Hour Method of Access: *(Check One)* Answering Service Pager

# of Treatment Tables: # of Massage Therapists:

Office Size (in sq. feet): # of Exam Rooms: