

UPDATE:

Dear ChiroHealth-Ohio Provider

Please update your current practice information.

ONE FORM per EACH Doctor's Name associated with the Clinic & Fed TIN#

Doctor's Name : _____

Clinic Name: _____

Complete Address: _____

_____ County: _____

FED. TIN# _____ Effective Start Date: _____

Individual NPI# _____

Medicare # _____

Medicaid# _____

Office Telephone: _____

Office Fax: _____

E-mail Address: _____

Please complete a updated **W-9 form** relating to your practice.

Return this information VIA FAX to: ChiroHealth-Ohio @ 440-449-1568

1099 – Practice Info