Annual Provider Information Update Form

OFFICE INSTRUCTIONS: *DUE NO LATER THAN MARCH 1st*
Please submit online, fax or email this completed document back to Soteria at fax # 770-455-4120 or email claims@soteriahealthcare.com.
This form is available to submit (online) at www.SoteriaHealthcare.com/downloads
*This updated form and practice information is required **annually** by Soteria Healthcare Network. Any questions/comments, please call 770-455-8190.*

Current Provider Information

Last Name: _____ First Name: _____
Practice Name (As it appears on W-9) _____
Office Tel. _____ Fax # _____ TIN # _____
NPI (Indiv) #_____ Medicare (Indiv) # _____ Medicaid (Indiv) # _____

Professional Insurance Carrier _____ Exp. Date: _____

- Per Claim Limit of Liability $_____ Aggregate Amount $_____

Business Liability Insurance Carrier: _____ Exp. Date: _____

Current Practice Address

Street Address _____
_____
City, State, Zip _____ County _____

Office Hours: _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun
Additional Comments About Office Hours _____
Email Address: _____
Web Site Address: _____
Languages Spoken: _____
Type of practice? (Group or Solo) _____
If Group Practice, please list the names (first and last) of all of the other providers practicing at this location.
_____
_____

Office Information

⇒ Total Number of Exam Rooms _____
⇒ Total Number of Exam Tables _____
⇒ Total Number of CAs Employed _____
⇒ Massage Therapy Offered At Practice ____Yes _____ No
⇒ Do You Accept New Patients At This Location? ____Yes _____ No
⇒ Do You Have Any Age Restrictions? ____Yes _____ No (If yes, describe) _____
⇒ On-Site X-Ray: ____Yes _____ No _____ Other (If Other, please describe) _____
  - Make/Model of X-Ray Machine: _____
  - Date of Last State Certification: _____

Do you also practice out of other locations? _____ Yes _____ No
If yes, please list other practice address(es)/locations on next page.

This Form Was Completed By (First/Last Name; Printed) _____

Today's Date _____

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Other Practice Address You See/Treat Patients At Include:

Street Address _____

_____

City, State, Zip _____

Office Tel _____ Fax # _____

Other Practice Address You See/Treat Patients At Include:

Street Address _____

_____

City, State, Zip _____

Office Tel _____ Fax # _____

Other Practice Address You See/Treat Patients At Include:

Street Address _____

_____

City, State, Zip _____

Office Tel _____ Fax # _____

DO NOT FORGET ...
"IF YOUR ADDRESS HAS CHANGED IN THE PAST YEAR…"

Please be sure to submit your updated W-9 "REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION" FORM.

This W-9 Form can be found and submitted in two ways:

1. Submit online by visiting www.SoteriaHealthcare.com/downloads; or
2. Visit https://www.irs.gov/forms-pubs/about-form-w-9 and fax your updated W-9 back to Soteria Healthcare at fax # 770-455-4120.

Questions, please call 770-455-8190. Thank you!