



DIRECTORY INFORMATION FORM

PLEASE COMPLETE THE ENTIRE FORM

Return with a copy of your W-9 for each location

To 918-641-0665 or elizabeth@oscipa.com

Is this an additional location? Yes _____ No _____

Name _____

Effective Date of Change _____

PREVIOUS INFORMATION – COMPLETE UNLESS NOTIFYING OF ADDITIONAL LOCATION

PREVIOUS Clinic Name _____

PREVIOUS Tax ID Number _____

PREVIOUS PHYSICAL Address _____

City _____

State _____

Zip Code _____

PREVIOUS Phone Number _____

PREVIOUS Fax Number _____

PREVIOUS MAILING/BILLING Address _____

City _____

State _____

Zip Code _____

NEW/ADDITIONAL OFFICE INFORMATION – PLEASE COMPLETE

NEW Clinic Name _____

NEW Tax ID Number _____

NEW PHYSICAL Address _____

City _____

State _____

Zip Code _____

NEW Phone Number _____

NEW Fax Number _____

NEW MAILING/BILLING Address _____

City _____

State _____

Zip Code _____

PERSONAL INFORMATION – PLEASE COMPLETE AND RETURN WITH W-9

Date of Birth _____

Social Security Number _____

Email Address _____

Chiropractic License _____

Individual NPI _____

Practice NPI _____

Website _____