DAVIS VISION
EYECARE REFRAMED℠

Provider Add Form

☐ **New Office Location** ☐ **Adding Doctor to Existing Location** **DV Provider#_____**

Is the office affiliated through a Retailer? ____(Y/N) If yes, who is the Retailer? _____

Provider Information			
Last Name:		First Name:	
Title (Circle one):	MD DO OD	SSN:	
DOB:		Sex (Circle one):	M F
Individual NPI #:		CAQH #:	
Medicaid # (Individual):		*Please note: CAQH attestation must be signed and dated within the past 30 days*	
Group/Office Name:		Group NPI#:	
Office Address:		Office city, State, Zip:	
Office Phone #:		Office Fax #:	
Office E-Mail address:		Medicaid # (Group):	

Please attach W-9 and sample HCFA 1500 Form for billing address (Name/Address to send Check Payments)

Materials shipping street address: _____

City: _____ State: _____ Zip: _____ County: _____

Please select below the services provided by your office:

____ Full Service (Exam, Eyeglasses & CLs)	
____ Exam Only	____ Eyeglasses & Contact Lenses
____ Exam & Contact Lenses	____ Eyeglasses Only
____ Exam & Glasses	____ Contact Lenses
____ Laser Surgery	

Languages Spoken:
☐ English ☐ American Sign ☐ Spanish ☐ Other_____

Hours of Operation (must be entered):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Attestation:
I understand and acknowledge that neither the submission of a completed Davis Vision, Vision Care Provider Application nor the execution of the Davis Vision Participating Provider Agreement constitutes acceptance as a Davis Vision Participating Provider. Acceptance as a Davis Vision Participating Provider is contingent on the acceptance by Davis Vision, Inc. of an applicant's completed Application, and on the execution by the applicant of the Davis Vision Participating Provider Agreement, and on the receipt by the applicant of the forms, manual and samples required for participation. Davis Vision, Inc. reserves the absolute right to determine which applicant is acceptable for participation and in which groups an applicant will participate.

*__Signature:__ _____ __Date:__ _____

*__Print Name:__ _____ *(Must sign and print name in full.)

Submit completed requests to Fax: 210-245-2369
❖ **Forms received incomplete will not be processed**