DAVIS VISION
EYECARE REFRAMED℠

Provider Change Request Form

RT REFERENCE #: ______________

Provider Information

Today's Date	
Requested by	
Requestor's Phone Number	
Effective Date of Change	_____ / _____/ _____ (MM, DD, YY)

Reason for Request

____ Change current Office Phone/Fax Number including Area Code
____ Change current Physical Address
____ Change current Shipping Address
____ Change current Billing Address **(Please include W-9)**
____ Change Tax ID Number **(Please include W-9)**
____ Add/Remove Panel ________________________ (please include a Member ID to identify the Panel)
____ Sell of practice/Ownership Change (**Please include W-9 and Bill of Sell**)

Current Office Information

Davis Vision Provider Number	
Office Name	
Current Address	Office Type: Physical ___ Ship To ___ Billing ___
Current City, State Zip Code	
Current Phone Number	( )
Current Fax Number	( )
Current Tax ID Number	
Practitioner's Name	

New Office Information

New Address	Office Type: Physical ___ Ship To ___ Billing ___
New City, State, Zip Code	
New Phone Number	
New Fax Number	
New Tax ID Number	

Submit completed requests to Fax: 210-245-2369

❖ **Forms received incomplete will not be processed**

Authorized Signature __________________________________ **Date**________________

03/24/2014; Rev. 04/29/2015