DAVIS VISION
EYECARE REFRAMED℠

Provider Termination Request Form

RT REFERENCE #: _____

☐ Terminate Office ☐ Terminate Practitioner

Provider Information

Today's Date	
Requested by	
Requestor's Phone Number	( )
Effective Date of Change	

Office and Practitioner Information

Davis Vision Provider Number	
Office Name	
Street Address	
City, State Zip Code	
Phone Number	( )
Fax Number	( )
Practitioner's Name (if multiple practitioner's per office, please indicate below)	
Practitioner's NPI	
Practitioner 2 Name	
Practitioner 2 NPI	
Do you have a Davis Vision Exclusion Frame Collection? ☐ Yes ☐ No	
Are you transferring the Frame Collection to another Provider/Office? ☐ Yes ☐ No	
If yes, to whom are you transferring the Frame Collection?	**Davis Vision Provider Number:** **Provider Name:** **Address:**
If no, please provide the address for Davis Vision to mail the shipping label and return box.	**Provider Name:** **Address:**

Reason for Termination

Submit completed requests to Fax: 210-245-2369

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

Authorized Signature _____ **Date**_____