

DAVIS VISION

EYECARE REFRAMEDSM

Provider Add Form

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

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

Is office affiliated with an existing Davis Vision office? _____ (Y/N) If yes, Davis Vision office # _____

Must Include a W-9 with the submission of the Provider Add Form or the request will be rejected

Provider Information – If multiple offices are involved, please include an attachment listing the offices.			
Last Name:		First Name:	
Title (Circle one):	MD DO OD	SSN:	
DOB:		Sex (Circle one):	M F
Individual NPI #:		CAQH #:	
Medicaid # (Individual):		Tax ID #:	
Group/Office Name:		Group NP I#:	
Office Address:		Office city, State, Zip:	
Office Phone #:		Office Fax #:	
Office Contact Name:		Office Contact Phone Number:	
Office E-Mail address:		Medicaid # (Group):	
Does your office meet The Americans with Disabilities Act (ADA) guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your office offer handicap access for the following?	Does your office offer services for the following?		Accessible by Public Transportation?
Building <input type="checkbox"/> Yes <input type="checkbox"/> No	Text Telephony (TTY) <input type="checkbox"/> Yes <input type="checkbox"/> No	Bus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parking <input type="checkbox"/> Yes <input type="checkbox"/> No	American Sign Language <input type="checkbox"/> Yes <input type="checkbox"/> No	Subway <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restroom <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental/Physical Impairment Services <input type="checkbox"/> Yes <input type="checkbox"/> No	Regional Train <input type="checkbox"/> Yes <input type="checkbox"/> No	

As an In-Network provider, you receive the Davis Vision Exclusive Collection, an additional 222 frames to your existing selection. Showcased on a compact rotating fixture, the Exclusive Collection is a display of top-selling eyewear offered to our members for low-to-no, out-of-pocket cost. You can also order these frames to sell to your non-members at your own determined price.

Materials shipping street address: _____

City: _____ State: _____ Zip: _____ Country: _____

Please select below the services provided by your office:

<input type="checkbox"/> Full Service (Exam, Eyeglasses & CLs)	<input type="checkbox"/> Exam Only	<input type="checkbox"/> Exam & Contact Lenses Only	<input type="checkbox"/> Exam & Glasses Only
<input type="checkbox"/> Eyeglasses & Contact Lenses Only	<input type="checkbox"/> Eyeglasses Only	<input type="checkbox"/> Contact Lenses Only	<input type="checkbox"/> Mobile
<input type="checkbox"/> Pediatric Services Provided	<input type="checkbox"/> Laser Surgery	<input type="checkbox"/> Other	

Languages Spoken:

English American Sign Spanish Other _____

Hours of Operation:

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 Network Operations by fax to 210-245-2369

03/24/2014; Rev. 1/11/16