DAVIS VISION
EYECARE REFRAMED℠

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? _____

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 NP I#:	
Office Address:		Office city, State, Zip:	
Office Phone #:		Office Fax #:	
Office E-Mail address:		Medicaid # (Group):	

Does your office meet The Americans with Disabilities Act (ADA) guidelines? ☐ Yes ☐ No

Does your office offer handicap access for the following?	Does your office services for the following?	Accessible by Public Transportation?
Building ☐ Yes ☐ No	Text Telephony (TTY) ☐ Yes ☐ No	Bus ☐ Yes ☐ No
Parking ☐ Yes ☐ No	American Sign Language ☐ Yes ☐ No	Subway ☐ Yes ☐ No
Restroom ☐ Yes ☐ No	Mental/Physical Impairment Services ☐ Yes ☐ No	Regional Train ☐ Yes ☐ 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:

☐ Full Service (Exam, Eyeglasses & CLs)	☐ Exam Only	☐ Exam & Contact Lenses Only	☐ Exam & Glasses Only
☐ Eyeglasses & Contact Lenses Only	☐ Eyeglasses Only	☐ Contact Lenses Only	☐ Mobile
☐ Pediatric Services Provided	☐ Laser Surgery	☐ 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

Updated 11/02/2015