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 Network Status to No New Patients (NNP)
____ Change current **Physica**l Address
____ Change current **Shipping** Address
____ Change current **Billing** Address **(Please include W-9)**
____ Change Tax ID Number **(Please include W-9)**
____ Sell of Practice/Ownership change (**Please include W-9 and Bill of Sell**)

☐ **Yes** ☐ **No** **Does the Practice currently have the Davis Vision Exclusion Collection?**

Current Office Information

Davis Vision Provider Number	
Office Name	
Current Address	
Current City, State Zip Code	
Current Phone Number	( )
Current Fax Number	( )
Current Tax ID Number	
Practitioner's Name	

New Office Information

New Address	
New City, State, Zip Code	
New Phone Number	
New Fax Number	
New Tax ID Number	

* Authorized Signature:_____ Date: _____

* Print Name: _____*(Must sign and print name in full)

Submit completed requests to Network Operations by fax to 210-245-2369